1-1-1981

The effect of client choice of therapist on therapy outcome.

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THE EFFECT OF CLIENT CHOICE OF THERAPIST ON THERAPY OUTCOME

A Dissertation Presented

By

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Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of

DOCTOR OF EDUCATION

September 1981

Education

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ACKNOWLEDGEMENT

The author wishes to express his sincere thanks to his committee members, Chairperson Dr. Allen Ivey and members Dr. John Wideman and Dr. Doris Shallcross, for their unwavering enthusiasm, support, and guidance throughout this investigation.

Sincere thanks are also expressed to Dr. Raphael Vitalo and Janet Troutman for their willingness to undertake the investigation and their assistance with technical and administrative aspects of the study. Appreciation and gratitude are also due the clinical staff and clients who participated in the study.

Special thanks are due the New Zealand "proxy" examining committee, Chairperson Dr. John Small and members Dr. Bill Black and Dr. Andrew Hornblow, for their support and assistance in conducting the oral examination, and to Harold J. Dupuy and Charles B. Truax for permission to use their questionnaires, the General Well-Being Schedule and the Current Adjustment Rating Scale, respectively.

Finally, my sincere gratitude is expressed to my wife, Margie, and Jeanette Shopland for their encouragement, ideas and suggestions over the entire course of this undertaking.

ABSTRACT

The Effect of Client Choice of Therapist on Therapy Outcome

September, 1981

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This study was designed to investigate the notion of client choice of therapist as an alternative method of matching client and therapist to enhance therapeutic outcome. Subjects were 42 walk-in clients at an inner-city community mental health center who were randomly assigned to one of three groups (n = 14 for each group): a. clients who viewed a slide/sound presentation about all available therapists and then chose their own therapist; b. clients who viewed the presentation and were assigned to a therapist by the center's clinical director; and c. clients who were assigned to a therapist by the clinical director without seeing the presentation.

The slide/sound presentation (i.e., the treatment procedure) was constructed by having the center's eight, full-time therapists develop their own self-presentations using color slides and audio-taped messages. The individual messages were combined on a master tape with the order of presentation randomized.

The experimental design used in the study was a three group version of an experimental group-control group, pretest-posttest design.

Therapeutic outcome was measured by gathering both client and therapist estimates of overall adjustment and severity of presenting problems. In addition, data regarding clients' initial reactions to the center, type of termination, and number of therapy sessions were recorded. Clients were tested before therapy and either at termination or after three months, whichever occurred first.

Multivariate analyses (MANOVA) indicated that at posttesting there were no group differences in number of therapy sessions, severity of presenting problems, General Well-Being Schedule scores, Current Adjustment Rating Scale scores, or therapist's satisfaction with therapy. In addition, there were no group differences in type of terminations or initial reactions to the center. Further analysis revealed that 75% of all clients improved significantly as a result of therapy and that clients in all three groups made similar gains.

The results were discussed in relation to the literature indicating that there are compelling social, ethical and legal reasons for suggesting that all clients have the right to choose their own therapist or therapy.

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CHAPTER I

INTRODUCTION

This chapter contains three sections. The first traces the development of the notion of matching client and therapist to maximize therapeutic outcome from the early recognition that certain client-therapist pairings enhance the therapeutic process, to the more recent notion that clients should be able to select their own therapy or therapist from among available alternatives. The second section develops the notion of client choice of therapist and discusses the practical importance and implications of such a procedure. The third section includes the rationale and design of this study.

Development of the Notion of Matching

In their critical review of issues, trends and evidence in research in psychotherapy, Strupp and Bergin (1969, pp. 19-20) stated that "the traditional question, 'Is psychotherapy effective?', is no longer fruitful or appropriate." Perhaps a better question is that posed by Ivey and Authier (1978, p. 232) which encapsulated the views of earlier writers (Bergin, 1971; Keisler, 1966; Paul, 1967; Strupp & Bergin, 1969): "Which therapy for which individual under what conditions?" This suggested "matching" of client, therapist and therapy style to optimize favorable therapeutic outcome seems both pragmatically and ethically preferable to what happens in the typical treatment setting where clients are randomly assigned to therapists,

assigned to equalize therapist caseloads, assigned to therapists according to an intake worker's intuitions, or assigned by some other means which may or may not be related to therapeutic outcome.

The notion that certain client-therapist pairings enhance the therapeutic process has received consistent support in the research literature. Clemes and D'Andrea (1965) tested the effect that compatibility or incompatibility in an initial interview has on patient anxiety and found that compatible client-therapist pairings resulted in less patient anxiety while incompatible pairings contributed to higher patient anxiety. Furthermore, it was suggested that low compatibility could lead to premature termination of therapy by the client. More importantly, Sapolsky (1965) in a study of the degree of interpersonal compatibility between client and therapist and Luborksky, Chandler, Auerback and Cohen (1971) in an exhaustive review of 166 studies of predictors of outcome in individual psychotherapy concluded that similarity or compatibility between client and therapist was a significant variable affecting treatment outcome. However, a more recent review of research examining the effects of similarity between client and therapist and positive outcome (Ross, 1977) indicated that at best only a weak positive relationship existed. Rather than being an argument against the concept of matching to maximize outcome, Ross's conclusion suggested that the factors involved in mat ng were more subtle and complex than could be described by such gross variables as compatibility or similarity. For certain clients, for example, similarity to the therapist was seen as negative and affected outcome accordingly. While similar findings were reported by Beutler, Johnson,

Neville, Elkins and Jove (1975), i.e., that initial client-therapist similarity could be inversely related to the therapist's persuasive influence, their results also suggested yet another complication: that the therapist's credibility as perceived by the client could affect outcome.

Utilizing the wealth of evidence that certain client and therapist pairings could affect the quality of the therapeutic process and its outcome, a number of therapists have attempted to match clients and therapists to maximize therapeutic gain (for a summary see Berzins, 1977). In spite of these efforts, however, to date no single method of matching has been demonstrated both effective and practical enough to be used extensively. Furthermore, all of these attempts to match client and therapist have assumed that the therapist or agency should determine the match.

Attempts to match client and therapist served to emphasize the fact that therapy is a social situation involving the mutual expectations of the participants. This knowledge led to an examination of role complementarity between client and therapist, that is, the extent to which participants know what is expected of them and behave accordingly. The discovery that this role complementarity was frequently absent was thought to be due to client deficiencies, such as lack of knowledge of the process of therapy and/or a lack of first-hand experience in therapy (Lennard & Bernstein, 1960). Naturally this prompted attempts to increase role complementarity by inducting the client into the patient role, in effect teaching clients what was expected of them. Only rarely was it suggested that therapists should

be more cognizant of client needs and preferences and structure therapy accordingly. This latter type of matching would require only that therapists ascertain client needs, desires, and preferences.

Indeed, there already exists a large body of literature demonstrating that clients themselves have definite preferences regarding therapists and therapy orientations (see, for example, Rosen, 1967; Simon, 1973). While these preferences could logically be made the basis of a matching scheme, an immediately obvious extension of the idea of using client preferences to match clients with therapist or therapy would be to provide clients with prior information about available therapists and therapy orientations and allow them to choose their own (Coyne & Widiger, 1978; Enright, 1975; Lieberman, 1975). Client selection already operates in the field delimited by the term "t-group", where it is recognized that clients, or group participants, choose the group experience they desire. In fact, an operating rule of most t-groups is that participation be strictly voluntary, i.e., the client's choice. One of the problems in this consumer situation is that group leaders "have clearly failed to differentiate [their] offerings for the clients [they] serve...the real task will be to provide reasonable and recognizable distinctions that clients can use" (Lieberman, 1975, p. 246). Choice, of course, means little unless accurate prior information regarding alternatives is available. In the case of growth group experiences, the group leaders are being urged to be more aware of and responsive to client needs, demands, levels of knowledge and levels of sophistication. A positive factor in this situation is that group therapists and trainers have at least

recognized the importance of client influence and preference. The same could occur in individual therapy.

Considerable ethical and theoretical support for the notion of clients choosing their own therapists is derived from the growing movements advocating client rights and consumerism-in-counseling (Margolis, Sorenson, & Galano, 1977; Morrison, 1978). Allowing clients to select the therapist and type of therapy they feel they need is entirely coincident with both movements' goals: delineating clients' rights, demystifying the process of therapy, and increasing clients' participation in the process of their own therapy (Weinrach & Morgan, 1975; Winborn, 1975). In addition there are suggestions that client selection would have positive effects not only on both the process and outcome of therapy (Enright, 1975; Lazare, Cohen, Jacobsen, Williams, Mignone, & Zisook, 1972; Ryan, 1971), but also on the chosen therapists and their attitudes toward their work (Lazare et al., 1979; Palmer, 1973).

In spite of strong support from the client rights movement and the suggested benefits to both clients and therapists, there has been little research designed to investigate the effects of client choice on the therapeutic process. Furthermore, since the notion of client choice of therapist runs counter to existing practice in most mental health agencies, and since the necessity of supplying clients with accurate information with which to make a reasoned choice might be threatening to many therapists, it is not surprising that almost all of the published client-choice studies involving individual counseling are analogue studies.

Importance and Implications of Client Choice

Any discussion of client-therapist matching to optimize therapeutic gain is immediately complicated by the almost overwhelming complexity and number of factors involved (see Strupp & Bergin, 1969). Thus, while it is widely recognized that certain client-therapist pairings can enhance therapeutic outcome, this complexity has prohibited the development of any simple, valid method of matching that has been demonstrated to be both effective and practical enough to be used extensively.

The suggestion that clients themselves be allowed to select the therapy or therapist of their choice based on accurate, prior information about available alternatives is a simple, practical alternative to previous matching attempts that have assumed that the therapist or agency should determine the match. The implications of such a procedure are far reaching.

The notion of increasing client participation in therapy and outcome evaluation has been made mandatory for publicly funded mental health centers through the Community Mental Health Centers Amendments of 1975 (PL 94-63). This law made consumerism-in-counseling a reality by specifying "the need for consumer evaluation and a broader range of citizen appraisal and involvement" (Margolis, Sorenson, & Galano, 1977, p. 13). Thus, in one sense the idea of clients selecting their own therapists merely complies with the spirit and intent of an existing public law. Furthermore, philosophical and theoretical support for client choice of therapist is found in the accountability-in-counseling

movement of the early 1970's and the more recent client rights and consumerism-in-counseling movement (see the Personnel and Guidance Journal, December, 1977, a special issue on the topic of consumerism-in-counseling). In the following paragraphs, the implications of clients choosing their own therapists are discussed in terms of the possible impact on clients, therapists, and helping agencies.

Implications for clients. It is generally recognized that "because of the nature of the therapy situation, it is very easy for the patient, in the role of supplicant, to feel 'one down' in power to the therapist" (Rice & Rice, 1973, p. 194). The simple act of choosing might do much to equalize this inherent therapist-client power imbalance. Enright (1975) also suggested that by choosing their own therapists clients (a) would be taking responsibility for themselves, and (b) would be more committed to active involvement with their chosen therapists. Thus, there may be a number of positive outcomes associated with choosing for the clients involved.

Implications for therapists. Equally important may be the effects on the chosen therapists: (a) they might be more committed to working with clients who have chosen them, and (b) they might be more willing to make high risk interventions with clients who have chosen them. Palmer (1973) described a matching situation in which youth workers who were systematically matched with youths reported higher job satisfaction and stayed in the job longer than unmatched workers. It seems reasonable to anticipate similar effects when using a matching system involving client choice of therapist. Of further interest in

this regard is the research of Lazare, Cohen, Jacobsen, Williams, Mignone, and Zisook (1972) which revealed that treating client requests as legitimate consumer demands resulted in "increased morale amongst the therapists in our clinic" (p. 882).

One of the tenets of the consumerism-in-counseling movement is that the counseling process should be demystified by having counselors make explicit what they do (Sue, 1977). One way this might be done is by means of the psychoeducator model of helping described by Ivey and Authier (1978). The psychoeducator model involves teaching people new competencies using an educational rather than medical model: "Client dissatisfaction (or ambition) → goal setting → skill teaching → satisfaction or goal achievement" rather than "illness → diagnosis → prescription → therapy → cure" (p. 5). Client choice of therapist involves merely extending the psychoeducator model so that therapists provide accurate prior information about themselves and their methods that clients can use in deciding whom to seek help from. Provision of this type of prior information would simultaneously help to demystify the process of therapy and force therapists to be more explicit about and accountable for the services they provide.

Obviously, many therapists might find the notion of allowing clients to select them threatening. Additionally, what would be the consequences of an agency therapist never, or only infrequently, being selected? While the possible answers may be neither easy nor entirely palatable, it is equally important to acknowledge Morrison's (1978) strong assertion that psychiatric clients have the right to be informed that the services they receive are often "ineffective and ethically

questionable" (p. 148). It follows from this that clients should have the right of informed choice, despite possible negative consequences for some therapists.

Implications for helping agencies. In most matching schemes reported in the literature to date, the matching has been done by the agency or therapist, i.e., matching based on therapist or agency needs and preferences, or their perceptions of what would be best for clients. It is clearly the case that "there is a tendency for a treatment program to reflect the philosophy of a director or a therapeutic team" (Ewing, 1977, p. 14) and not the needs of individual clients. Allowing clients a choice of therapist would force agencies to be explicit about their services and more client-conscious in their structure and organization. Winborn's article (1977) on "honest labeling", for example, outlined the types of information that could be given to clients to enable them to make informed choices about the goods and services they use.

According to Ryan (1971), client choice would force agencies to compete for clients by offering different treatment alternatives. Rather than taking what they were offered, clients could select the therapy or training they felt suited them best. This would place agencies more in the role of psychoeducational helpers and less in the role of traditional medical model therapists.

While not all clients, therapists or agencies would welcome the changes resulting from a client self-matching scheme, two factors seem to lend strong support to implementing such a scheme: (a) the strong

client rights and consumerism-in-counseling movements are entirely coincident with client choice, and (b) there are suggestions that the act of choosing will have benefits for both clients and therapists.

Rationale and Design of the Study

Although an intriguing idea having face validity and obvious appeal to advocates of clients' rights, client choice of therapist has received scant attention from researchers. For the most part those studies that have addressed the question have been analogue studies, usually with sampling and other methodological shortcomings as well. In fact, eleven of the twelve studies involving choice in individual counseling situations reviewed in Chapter II were analogue studies. Thus, to date the consumerism-in-counseling movement has been largely political and the question of what effect client choice has on counseling outcome remains unanswered.

Because of the importance and implications of the notion of client choice of therapist, the present study sought to investigate the effects of client choice of therapist on therapy outcome in an authentic therapy setting using actual therapists and clients. Specifically, the study was designed to:

1. Develop a practical, simple procedure that allowed clients to select the therapist of their choice on the basis of prior, accurate information.
2. Compare the therapeutic progress and outcome of clients who chose their therapists with clients who were assigned

to therapists via the agency's usual procedure (in this instance the match was determined by the Center's Clinical Director).

To accomplish this, walk-in clients at the W.W. Johnson Life Center, a community mental health center in Springfield, Massachusetts, were used as subjects and the eight, full-time counseling staff as therapists. Outcome measures were chosen to satisfy both the recommendations that outcome criteria be multiple and involve multiple raters (Farnsworth, Lewis, & Walsh, 1971; Fiske, Hunt, Luborsky, Orne, Parloff, Reiser, & Tuma, 1970), and that they be as brief, non-obtrusive, and nondisruptive to the Center's service orientation as possible. A color slide/audio tape format was used to give clients prior information about the eight therapists, and all clients and therapists completed the various outcome instruments before and after therapy. A detailed discussion of the design used in this study is included in Chapter IV.

CHAPTER II

REVIEW OF LITERATURE ON CLIENT-THERAPIST MATCHING

Before reviewing the research on client choice of therapist, the entire issue of matching itself is reviewed. This section begins with a brief review of the substantial body of literature on client-therapist pairing that both suggests the promise of enhanced therapeutic outcome and reveals an almost overwhelming number and complexity of factors to be considered in effecting a match. Next, the importance and implications of matching are discussed and research describing systems of matching is evaluated. Since role complementarity between client and therapist is related to the issue of matching, a discussion of methods used to induct clients into therapy follows.

An obvious alternative to role-induction procedures is for therapists and helping agencies to modify their offerings to suit client needs and preferences. Since the entire issue of client choice is based on the assumption that clients do indeed have identifiable preferences regarding therapists and therapies, the literature on client preferences is briefly reviewed. A related body of literature has developed from the client rights and consumerism-in-counseling movements, and the consumerism rationale for client choice is reviewed.

Finally, the published research having more direct relevance to client choice of therapy or therapist is presented.

Review of Literature on the Effects of Certain Client-Therapist Pairings

Any discussion of client-therapist matching to optimize therapeutic gain is immediately complicated by the almost overwhelming complexity and number of factors involved. Strupp and Bergin's (1969) review of issues, trends and evidence in therapy identifies some of those variables: (a) client variables: sex, age, race, socio-economic status, personality factors, presenting problem, attractiveness, values, attitudes, motivation for therapy, openness to influence; (b) therapist variables: age, sex, race, experience, education, title, warmth/acceptance/empathy; (c) theoretical orientation and techniques. Thus it would seem that any effective scheme for matching clients with therapists would necessarily have to be far more detailed and have greater predictive power than present knowledge and research permits. Nevertheless, the knowledge that certain client-therapist pairings result in greater client gains is extremely significant. A review of some of the literature contributing to that knowledge confirms both its significance and complexity.

Early research (Strupp, 1958) has demonstrated that the therapist's reaction to the client colors the course of therapy. Strupp found that the therapist's attitude to the client was correlated with diagnosis and prognosis, treatment plans and goals, form of treatment proposed, frequency of sessions, and empathy ratings of the therapist's behavior with the client. These findings have obvious implications for matching. A more recent study (Brown, 1970) compared experienced and inexperienced counselors' first impressions of clients. While it was observed that

inexperienced counselors tended to be more positive in their overall first impression ratings of clients than experienced counselors, both groups of counselors liked best those clients they saw as having the most potential for change and were more satisfied with the progress those clients made. Again, these findings suggest that certain client-therapist pairings may be more desirable than others since therapists hold different attitudes toward different clients.

In a study looking at the effect of client stimulus on therapist response, Heller, Myers, and Kline (1963) had 34 interviewers-in-training (graduate students in psychology) conduct half-hour first interviews with four client types: (a) dominant-friendly, (b) dominant-hostile, (c) dependent-friendly, and (d) dependent-hostile. Rating the interviews revealed that dominant client behavior evoked significantly more interviewer dependence while friendliness evoked more interviewer friendliness, leading the authors to describe therapy as a "reciprocally contingent interaction". A similar study by Beery (1970) presented tape recorded hostile and friendly client statements to 16 experienced therapists (more than four years' experience) and 16 inexperienced therapists (graduate students in clinical psychology). Therapists listened to each client statement and then recorded their responses. The responses were then rated by judges using the Therapeutic Climate Scale. The results demonstrated that client attitude (hostile-friendly) influenced both experienced and inexperienced therapists' responses and that therapists in both groups responded more positively to friendly rather than hostile client statements, although experienced therapists responded more positively to both client types than did inexperienced

therapists. While these studies can be criticized (both are analogue studies using client actors or client statements under simulated interviewing conditions), the importance of the findings lies in the fact that each participant's behavior affects the other, sometimes favorably, sometimes not. Therapists, at least, should be aware that this is happening and acknowledge situations in which certain clients are being perceived and responded to negatively.

The client, too, brings prejudicial attitudes to therapy. Something as seemingly innocuous as the help-giver's title can color clients' preconceptions of the help they will receive (Strong, Hendel, & Bratton, 1971). Asked to rate the titles "Counselors", "Advisors" and "Psychiatrists", female college students responded by rating counselors and advisors as similar but markedly different from psychiatrists. Respondents saw counselors/advisors as more friendly, polite and warm, as helping best with educational and vocational problems, and as resources for increasing self-knowledge and self-development. Psychiatrists, on the other hand, were rated as colder, more intelligent, decisive, analytic, rejecting, and humorless and as the best choice when faced with severe or personal problems. Thus, it may well be that in situations where alternatives do exist, clients choose the helper they want to work with, i.e., a method of self-matching. The information governing their choices, however, may or may not be accurate.

While clients may have expectations about what counseling will be like, these expectations may or may not affect the counseling relationship. Grosz (1968) randomly assigned 30 male university students to

three groups: (a) those given positive information about counseling, (b) those given negative information, and (c) a control group. Each subject was then assigned to one of the six counselors and completed a 30 minute first interview. Client and counselor ratings of the interviews demonstrated that: (a) counselors did not view the relationships they formed with subjects from the different groups as different, and (b) client groups did not view their relationships with counselors differently. Although interesting, the results of this study cannot be generalized to wider populations and authentic counseling relationships.

In addition to clients' and therapists' attitudes and their interactive effects, a number of other factors have been shown to affect the therapeutic process. One of the most widely researched has been the client's socio-economic status (SES). Since they recognized that the poor were less preferred as clients, stayed in therapy for less time and had expectations about therapy that did not match with therapists', Brill and Storrow (1960) argued that therapists should begin offering more than one type of treatment for these lower SES clients. Haas (1963) suggested that the failure of therapists and lower SES clients to communicate was due to the different values and attitudes typical of the two classes represented, i.e., middle-upper class therapists and lower class clients. Baum and Felzer (1964), Gould (1967), Jacobson (1965), and Yamamoto and Goin (1965) described attempts to modify treatment programs to accommodate the special needs of poor clients, i.e., types of matching.

An interesting study by Mitchell and Namenek (1970) compared

97 therapists' social class (54 clinical psychologists, 43 psychiatrists) with the social class of the clients most typical of their caseloads. Since all therapists tend to be upper-middle class when rated on SES, another means of determining their social class had to be used. Thus, in this study therapists' social class was measured by rating their parents' social class. It is worth noting that only 5% of all therapists asked consented to participate in the study. Results indicated that upper class therapists were more likely to have upper class clients while lower class therapists were more likely to have lower class clients. Clinical psychologists were more likely to come from a lower class background than psychiatrists and their typical client was more likely to be lower or lower middle class. Whether the results were due to therapist selection of client or client selection of therapist is uncertain. It was suggested that while clients may initially choose their therapist, after an initial interview, therapists select those clients they prefer to treat.

When therapists in private practice were considered, there was no difference in SES background between psychologists and psychiatrists and yet psychiatrists saw more upper class patients and psychologists more lower class patients. In this situation it appeared that clients were choosing therapists differently, perhaps on the basis of the prestige associated with the therapist's title or a referral (upper class clients may have been referred by doctors to psychiatrists while lower class clients may have been referred by ministers and social workers to psychologists).

In both situations the way in which the matching occurs is

important. A forced match may have negative implications for outcome. In contrast, clients who choose their therapist may be more motivated to enter therapy and undergo change; they may be more willing to assume responsibility for their own behavior; and the act of choosing may itself be empowering to the client, thus helping to equalize the inherent status differential between client and therapist. A study of bias in the non-therapeutic interview situation (Williams, 1974) indicated that this status differential may strongly affect respondents' behavior. The greater the status disparity between interviewers and respondents the greater the tendency for respondents to bias their responses. Low status respondents will defer to high status interviewers by giving simple agree/disagree answers, and by giving the right, or expected, answers.

Another factor that has been extensively studied is race of client and therapist. Yamamoto, James, Bloombaum, and Hattem (1967) demonstrated that racially biased therapists tended to avoid working with minority group clients. In a previously cited study by Williams (1974) involving non-therapeutic interview situations, Black clients responded differentially to White and Black interviewers, tending to give what they thought was the proper or expected answer.

An extensive review of the research on therapist-client racial similarity by Sattler (1977) revealed that while Black clients frequently benefit from therapy with a White therapist, this does not mean that White therapists are as effective as Black therapists. When given a choice, Black clients tend to prefer Black therapists while Whites do not seem to have such a clear-cut preference. It has also

been shown that Black clients use mental health services less, drop out of treatment earlier, are discharged earlier, and receive one-to-one therapy less often than White clients. These findings have been used in procedures designed to more closely match mental health services with minority-group needs.

While client-therapist sex pairing has been relatively sparsely researched, there is some evidence that mixed-sex pairs communicate more effectively than same-sex pairings (Berzins, 1977). However, Howard, Orlinsky, and Hill (1970) found that following therapy female clients were more satisfied with female therapists. Hill (1975) reported that same-sex pairings resulted in more discussion of feelings by both counselor and client. Thus, while pairings on the basis of sex have been found to affect the therapeutic process, no consistent trend is yet evident.

Review of Research on Matching Schemes

Utilizing the foregoing and other evidence that certain client and therapist pairings can affect the quality of the therapeutic process, a number of therapists have attempted to match clients and therapists to maximize therapeutic gain. One of the first such attempts at matching involved the A-B variable. Whitehorn and Betz (1954) first noted that some therapists (labeled "A" therapists) were more effective with schizophrenic patients than others (labeled "B" therapists) were. These two groups of therapists were later found to differ in their response patterns on the Strong Vocational Interest Blank (Betz & Whitehorn, 1956). "A" therapists were found to have

interests most like those of lawyers and unlike those of math-physical science teachers. They were found to work best with schizoid, distrustful, extrapunitive clients. "B" therapists had interest patterns similar to those of math-physical science teachers and unlike those of lawyers. They were found to work best with neurotic, trusting, intrapunitive patients. More recently Heaton, Carr, and Hampson (1975) reviewed the A-B variable literature and concluded that the factor was far more complex than had been reflected in earlier research. They also noted that many studies had failed to include type "B" therapists and suggested that true "B"s may be vanishing. Another recent review of A-B literature by Razin (1977) concluded that the A-B variable has not been a consistent predictor of outcome. Its usefulness in therapy has not been demonstrated.

An early scheme for diagnosing personality that seemed to have direct relevance for matching was Leary's system of Interpersonal Diagnosis of Personality (Berzins, 1977; Leary, 1957). The theory outlined a means whereby individuals could be classified in terms of their predominant interpersonal behaviors. These behaviors were represented by two bipolar dimensions (dominance-submission, love-hate) organized in a circular arrangement containing eight major subcategories. The theory stated that in dyadic interactions individuals generally reciprocated the other person's affective orientation (love elicits love, hate elicits hate) while complementing each other on the dominance-submission dimension (dominance elicits submission and vice versa). Since classifying people's stances on these two bipolar dimensions was a relatively easy task, there were

immediate implications for matching in therapy.

An important analogue study by Heller, Myers, and Kline (1963) furnished support for the main hypotheses of the Leary personality theory by demonstrating that patient dependency tended to elicit therapist dominance, while patient friendliness tended to elicit therapist friendliness. However, in spite of these findings and Berzins' (1977) assertion that "the classification of therapists and patients into the quadrants or categories of the Interpersonal Circle seems the most promising beginning toward a serious investigation of therapist-patient pairings" (p. 240), outcome research based on the theory remains scant, perhaps because the process of assessing both client and therapist personality dimensions and then determining the optimum match appears to be overly time-consuming and involved.

A different type of matching scheme, known as the Indiana Matching Project (Berzins, 1977), was developed over a four year period in a short-term, crisis-oriented college clinic. A total of 751 patients were assessed as either high or low on four basic roles (avoidance of others, turning against the self, dependency on others, turning toward others and self), thus yielding eight predictor scores. The 10 participating therapists were assessed as high, moderate or low on six personality dimensions (impulse expression, ambition, acceptance, dominance, caution, abasement) yielding 18 therapist predictor scores. Patients and therapists were then either randomly matched or led to believe they were matched (called "placebo compatibility"). After three weeks of therapy, outcome was assessed using both client and therapist ratings of improvement. Pairings were analyzed to identify

therapeutically favorable interaction effects. While the results were consistent with Leary's (1957) personality theory, the study's main objective was "to generate guidelines for future therapist-patient pairings in this clinic" (Berzins, 1977, p. 243). Once therapist and patient profiles are known, "it is then easy to recast the empirically determined interaction effects into a matrix which specifies the hypothesized favorability or compatibility of pairing any set of patient characteristics with any set of therapist characteristics" (p. 243). Subsequent outcome research using this system of matching clearly showed that optimally matched clients showed greater improvement than less closely matched pairs. Also of interest, however, was the finding that "placebo compatibility" patients' improvement was no different from that of unmatched patients. Expectancy of favorable match was not, therefore, sufficient to engender significant improvement.

The major shortcoming of this successful matching procedure was the lack of generalizability of the patient-therapist interaction matrix to other clinic settings. The same experimental procedure would need to be repeated in any other clinic intending to implement the scheme, a fact that perhaps explains the dearth of subsequent, supportive research data.

Another attempt at matching involving client-therapist compatibility was reported by Gassner (1970). Twenty-four theological students completing a summer program in pastoral counseling each acted as therapists and conducted therapy with two clients. Therapists and clients were matched (high compatibility) and mismatched (low

compatibility) on the basis of their scores on the Firo-B Scales. While clients matched for high compatibility viewed their relationship with therapists significantly more favorably than those matched for low compatibility, therapists did not report similar views. High compatibility matched clients did not show greater improvement than low compatibility matched clients. However, the evaluations were conducted after only three weeks of therapy. This and other shortcomings limited the usefulness of the results.

There have been suggestions that choice of therapy should depend on what is being treated (e.g., symptoms versus perceptions, cognitions and affect) and that multiple treatment approaches may be better than one alone (Marmor, 1971). This type of approach was an attempt to more closely match therapeutic technique with presenting problem and assumed that not all problems or clients were amenable to any one mode of therapy. Two examples of this type of approach can be found in Brady (1968) and Marks and Gelder (1965), both of which suggested that behavior therapy and dynamic therapy used with the same client (concurrently or in sequence) often brings about better results than either used alone. While this multiple therapy approach appears to have merit, an extensive cataloguing of effective therapy-problem pairings would need to be developed for the approach to be of use to practitioners.

Palmer (1973) described a successful system of matching used with juvenile delinquents and correctional workers in an institutional setting that was part of California's community treatment project. Workers were classified as one of two general types: (a) Relationship/

self-expression oriented: tended to help youths understand their own strivings and needs. These workers liked to be closely involved with clients, formed close relationships with youths, and encouraged direct verbal interactions. (b) Surveillance/self-control oriented: tended to be more authoritarian and controlling. These workers preferred to maintain social distance and formality in working with youths; their goal was behavior control. Classification of workers was based on the results of a two hour interview and a checklist of worker behavior. It was estimated that only 10% of all workers were mis-classified between 1961 and 1971.

Youths were classified according to nine different types on the basis of their previous histories and behavior while in the institution. Youths and workers were then matched according to the following guidelines: (a) Relationship/self-expression oriented workers were thought to work well with youths who were communicative and alert, impulsive and anxious, or verbally hostile and defensive. Such youths tended to come from intact middle or upper-middle class homes and were concerned with issues of independence and personal accomplishment. (b) Surveillance/self-control oriented workers were thought to work best with anxious, dependent youths who needed and liked being told what to do. Such youths tended to be more compliant and accepting of control.

Matching resulted in a failure rate (defined as parole revocation or court recommitment) of 23% after a 15-month follow-up versus 49% for unmatched youths. This difference was significant ($p < .01$). At 24 months the failure rates were 34% and 57% ($p < .05$). Also, matched

youths had a lower arrest rate after favorable discharge from the California Youth Authority ($p < .05$). This study represents a matching approach that could be replicated in other settings. It demonstrates that matching, even on rather general characteristics, can affect outcome. Of additional interest in this situation was the fact that workers who were matched with youths reported higher job satisfaction and stayed in the job longer than unmatched workers. Thus, matching may have benefits for both clients and therapists.

Another successful matching study using delinquents in a correctional setting (Levinson & Kitchener, 1966) compared four methods of assigning inmates to counselors: (a) randomly assigned, (b) Q-sort matching using the Edwards Personal Preference Schedule to pair similar personalities, (c) counselor selection of preferred clients, and (d) inmates choosing other inmates they wanted to be in group therapy with. Comparison of the four methods was made after five months of treatment. Outcome measures included school grades, vocational work grades, cottage adjustment grades, minor and major misconduct reports, number of inmates paroled, and number of boys who failed to adjust. The results indicated that the Q-sort group scored significantly better in terms of the mean rank over all the criteria ($p < .01$). This study comparing the efficacy of different methods of matching would have been even more interesting if a fifth method, namely client selection of counselor, had been included.

Review of Literature on Client Role Induction

So far this discussion has dealt with the complexities of matching and descriptions of some matching attempts. Most such attempts have assumed that the therapist or agency should determine the match of client and therapist. Thus, while there is an awareness that therapy is a social situation involving the mutual expectations of the participants, it is also clearly the case that treatment tends to reflect agency or therapist beliefs (Ewing, 1977), and not necessarily the beliefs or needs of the client. In fact, in therapy role complementarity between client and therapist is usually absent because (a) the client has little information about therapy or the therapist, (b) the relationship is so complex that clients almost need to experience it to understand it, (c) clients often enter therapy in distress and are therefore unable to function appropriately, and (d) the therapist knows what to expect while the client does not (Lennard & Bernstein, 1960). Too often the solutions for increasing this role complementarity are similar to those suggested by Lennard and Bernstein, and Garfield (1971), which were to induct the client into the patient role, i.e., teach clients what was expected of them.

There have been a variety of successful induction techniques reported in the literature. Hoehn-Saric, Frank, Imber, Nash, Stone, and Brattle (1964) used a Role Induction Interview to teach clients about the process of therapy. After four months of therapy, the experimental group of clients was rated as significantly more improved than a control group. A follow-up to this study (Lieberman, Frank,

Hoehn-Saric, Stone, Imber, & Parde, 1972), however, reported that the rated differences between the experimental and control subjects had disappeared after five years. The value of the role induction procedure, the authors concluded, was that it accelerated the process of change.

Truax and Wargo (1969) used a method of "vicarious therapy pretraining" that involved "presenting to prospective patients a 30-minute tape recording of excerpts of 'good' patient in-therapy behavior" (p. 440). The procedure was aimed at teaching clients the role of client and was found to have a significant impact on outcome. Extratherapy sessions before the second, third, fifth and eighth therapy hours were used by Warren and Rice (1972) in an attempt to reduce early therapy attrition. The extra sessions were designed to teach clients to participate more productively in therapy. Results demonstrated that the sessions resulted in fewer clients failing to complete at least 10 interviews and that client behavior in therapy was improved. Jacobs, Charles, Jacobs, Weinstein, and Mann (1972) used a short (15 minute) orientation-to-therapy session with their disadvantaged clients and a similarly short session with the therapists to orient them to the expectations and problems of lower class clients. Their results revealed that "even a limited educational procedure may be of considerable value in increasing the motivation and ability of both patient and doctor to work with each other" (p. 673). Strupp and Bloxom (1973) developed a role induction film ("Turning Point") and tested its effectiveness on clients undergoing group therapy. Use of the film resulted in more favorable outcome.

In an attempt to differentiate the effects of expectation of improvement and role induction, Sloane, Cristol, Pepernik, and Staples (1970) randomly assigned 36 clients to four different groups: (1) client assigned to therapist--no further pretherapy interventions; (2) clients told they could expect to feel better after four months (expectation); (3) clients had the process of therapy explained to them (role induction); (4) clients had the process of therapy explained and were told they could expect to feel better after four months (induction plus expectation). After four months of therapy, clients who received the explanation about the process of therapy had improved significantly more than those who had not ($p < .05$). Expectation had no effect on outcome.

Two recent reviews of psychotherapy research also support the notion of role induction procedures to enhance therapy outcome. Orlinsky and Howard (1978) reviewed nine favorable studies relating role induction to outcome and concluded that "there is evidence that educating patients for effective role performance is worthwhile" (p. 313). Similarly, Parloff, Waskow, and Wolfe (1978) suggested that "adequate preparation of the patient for psychosocial treatment may enhance treatment outcome" (p. 273). Thus, role induction has been shown to be effective. However, the alternatives of therapists giving clients more accurate prior information about themselves and their styles, or altering their services to fit the expressed needs and cultural values of the client, are seldom discussed. The latter alternative suggests that therapists could acquaint themselves with the client's needs and preferences and try to provide therapeutic services

that addressed those needs and preferences. This type of matching would depend only on ascertaining what client preferences actually were.

Review of Research on Client Preferences for Therapist and Type of Therapy

Simon (1973) suggested that client preferences regarding therapists and therapy might affect therapy in at least two ways: (a) the stronger the client's preference for a particular therapist, the greater that client's efforts to communicate with the preferred therapist; and (b) the stronger the preference for the therapist, the more likely it is that the patient will be influenced by the therapist's communications. These possibilities, coupled with the knowledge that "research to date, as well as clinical impressions, suggests that potential and actual clients have implicit and explicit ideas concerning the characteristics they would like manifested in their counselors" (Rosen, 1967, p. 787), suggest that using client preferences as the basis of matching might be a viable alternative to more traditional matching schemes, e.g., pairings based on therapist or agency needs and preferences, or their perceptions of what would be best for clients. Different types of clients having the same or different problems often prefer different modes of therapy and different types of therapists. In this section a number of research studies whose results support this notion are reviewed.

It is thought that certain types of alcoholics do better with certain types of treatment. For example, Alcoholics Anonymous seems to be most effective with alcoholics who are spiritually oriented,

responsive to peers, and enjoy socializing with reformed alcoholics, while psychotherapy seems to be most effective with introspective drinkers, those who want to reduce their drinking rather than abstain from it, those who view drinking as a psychological problem, and those who wish to talk to only a few people about their problem. It is assumed that alcoholics express their preferences for type of treatment by choosing who they will ask to help them, in part because of the way they expect to be treated by the therapist (Emrick, Lassen, & Edwards, 1977). An important factor in that assumption is the way in which alcoholics get accurate information about treatment alternatives in order to make a choice. Effective choice depends on accurate prior information about available alternatives.

Obitz (1975) studied 50 male alcoholics' perceptions of selected counseling techniques by showing them the C. R. Rogers and A. Ellis portions of the film, "Three Approaches to Psychotherapy" and having them rate the two therapists according to 30 adjectives on a 7-point bipolar scale. While the subjects saw Rogers as significantly more considerate, warm, friendly, patient, tolerant, sympathetic and passive, and Ellis as significantly more cruel, obnoxious, wise, insulting, annoying, hostile, unreasonable, perceptive, unpleasant, capable, cold, active and irritating, 44 out of the 50 ($p < .001$) said they would prefer Ellis's more directive style for themselves because they would find it more helpful. Since favorable client perceptions of a specific treatment technique might forestall early termination, a similar approach could be used in an actual clinic setting where therapists would videotape their styles and allow alcoholics or other clients to

choose the therapist whose style they felt would be most helpful to them.

Bordin (1955), whose statements were later supported by research conducted by Grater (1964) and Severinsen (1966), suggested that clients with personal problems felt that the therapist's personal characteristics were important in therapy while clients with educational or vocational problems attached little importance to the therapist's personal characteristics. They were more concerned with getting information from the therapist. More recent research by Newton and Caple (1974) demonstrated that university students with educational or vocational problems preferred counselors who gave them information. An additional finding was that all clients, even those with personal problems, expressed preferences for more direct assistance than counselors wished to give. Similarly, in a study in which open and closed-minded, black and white high school students were asked to express their preferences for a directive or non-directive counseling style after reading two case studies involving a problem regarding college selection, all groups expressed a preference for the directive style (Silver, 1972). Thus, it seems that for educational or vocational problems, at least, students in similar settings may prefer a directive, information-giving counseling style. This preference would be relatively easy to translate into a simple matching scheme.

Other researchers have similarly identified preferences of other client groups. Berzins and Ross (1972) found that addict patients who scored low on ego strength or high on a maladjustment index reacted more favorably to stimuli depicting peer helpers than they did to

stimuli depicting professional helpers. Fuller (1964) and Simon (1973) found that both males and females generally preferred male counselors over female counselors, while Walton's (1977) more recent study found that in an analogue choice situation, male subjects indicated a preference for male counselors and female subjects a preference for female counselors. Simon's findings also revealed that 40 year old therapists were preferred to 55 year old therapists who in turn were preferred to 25 year old therapists. Silver (1972) found that when only the counselor's race was known to clients, they preferred a counselor of the same race. Walton (1977) investigated the extent to which subjects representing four ethnic groups (Anglo, Black, Mexican-American/Chicano, Native American/Indian) preferred counselors from a similar ethnic group. Subjects were asked to select their preferred counselor for each of three problems from eight counselor photographs, a male and female representing each ethnic group. The predominant finding was that subjects preferred ethnically similar counselors. Thus, the detailed study of client preferences for types of therapists and conditions of therapy seems a productive area of inquiry, especially if the results can then be used to effect better client-therapist pairings.

Rationale for Client Choice of Therapist as a Method of Matching

The earlier discussion of the complexities of matching client and therapist on objective criteria and the research demonstrating that client preferences regarding therapist and therapy can be identified

suggest that allowing clients to match themselves with therapists or styles of therapy may be a simpler means to the same end, i.e., enhanced therapeutic outcome. For example, generalizing from Davis's (1939) early dietary research findings that, given enough varieties of food to choose from, even children, in the long run, select an adequate diet in terms of carbohydrates, protein, fats, minerals, and vitamins, it may be that clients too, if given sufficient and accurate information about available treatment options, will select the option that best meets their needs.

As discussed in Chapter I, in the broad field delimited by the term t-groups, it is recognized that clients, or group participants, choose the group experience they desire. In fact, an operating rule of most t-groups is that participation be strictly voluntary. One of the problems in this consumer situation is that group leaders "have clearly failed to differentiate [their] offerings for the clients [they] serve ... the real task will be to provide reasonable and recognizable distinctions that clients can use" (Lieberman, 1975, p. 246). It seems obvious that choice means little unless accurate prior information is available. In the case of group training experiences, the trainers must be more responsive to client needs, demands, levels of knowledge and levels of sophistication. A positive factor in this situation is that group therapists and trainers have at least recognized the importance of client influence and preference. Could not the same occur in individual therapy?

Earlier cited research by Beery (1970), Heller, Myers and Kline (1963) indicated that therapists respond differently to different

client types. These findings suggest that some clients may find themselves in therapy with reluctant and even negative therapists. It is even possible that such negative matches will be seen as resulting from the clients' lack of knowledge about the roles they are expected to play. Clients in such negative matches may find themselves undergoing role-induction training to socialize them to the process of therapy, as suggested by Lennard and Bernstein (1960) and demonstrated by Heilbrun (1972) and Strupp and Bloxom (1973). While the notion of role-inducting clients might be construed as unethical by some therapists, the literature on low SES clients (e.g., Brill et al., 1960; Haas, 1963; Yamamoto et al., 1965) which quite clearly indicates that lower SES clients receive markedly inferior treatment compared with other SES groups, suggests that most therapists assume this difference in treatment exists because lower SES clients are reluctant to engage in therapy, not amenable to treatment or unmotivated to change. Thus, role-induction procedures can be readily justified, and the client remains in a powerless, subservient position vis-a-vis the therapist. Only rarely has it been suggested that some client groups have needs, preferences and value systems that render the usual treatment modes ineffective and meaningless, and that therapists should change their styles and offerings to accommodate those differences.

One potentially powerful, but as yet unresearched alternative to role-inducting clients, would be to give clients sufficient information about available treatments and therapists and allow them to exercise their free choice. Not only would client choice of therapist result in a simpler means of matching, but the actual act of choosing might itself

have important meaning for certain groups of clients.

The terms powerless, isolated, supplicant, one-down, no-hope-in-life as descriptions of mental health patients have appeared repeatedly in the literature (Darley, 1974; Hare-Mustin, Marecek, Kaplan & Liss-Levinson, 1979; Morrison, 1978; Rice & Rice, 1973; Ryan, 1971). However, the act of choosing might do much to equalize this inherent therapist-client power imbalance. Anthony and Buell (1973) and Anthony, Buell, Sharratt, and Altoff (1972) have documented the lower recidivism rates of psychiatric aftercare patients who chose to attend an aftercare clinic when compared with those who did not attend. They suggested that the possible distinguishing factor was the attenders' motivation to stay healthy. It would, of course, be interesting to know what meaning the act of choosing to receive treatment held for those who attended the outpatient clinic.

Equally important might be the effects on the chosen therapists. As discussed in Chapter I they might be more committed to working with clients who have chosen them and more willing to make high risk interventions with clients who have chosen them. Positive effects on therapists in a matched situation have already been mentioned (Palmer, 1973) and it seems reasonable to anticipate similar effects under a system involving client choice of therapist.

It is widely recognized that a consumer situation exists in the field delimited by the term t-groups. This situation has forced group therapists and trainers to at least acknowledge the importance of client influence and preference. Given the movement towards account-ability in counseling in the early 1970's and, more recently, the

emphasis being given to client rights and consumerism in counseling, individual therapists are now having to face the same issues.

The concept of consumerism-in-counseling is generally taken to mean: (a) clients should be active rather than passive participants in therapy, (b) client rights should be made explicit to both parties, (c) the counseling process should be demystified by counselors explaining precisely what they do, and (d) the status-power differential between client and therapist should be more evently balanced (Sue, 1977).

Although few in number, most articles on client rights and consumerism-in-counseling contain suggestions as to how counselors can deal with those who demand outcome accountability and client rights. They tend to have a defensive tone to them. Few are written purely from the client's perspective. For example, although Penn (1977) stressed that consumerism in counseling did not have to be a threat to counselors, he warned that counselors had better pay attention to consumer demands. Trembley and Bishop (1974) offered a data collection strategy that would aid counselors and agencies in answering accountability questions. Winborn's article (1977) on "honest labeling" outlined the types of information that could be given to clients to enable them to make informed choices about the goods and services they use. Although certainly a laudable effort, it still represented the counselor's version of what information was necessary for clients to have. An equally useful but counselor-oriented article was Eberlein's (1977) list of those consumer rights that are protected by law and his suggestions as to how counselors could both protect themselves from

lawsuits and assure consumers that their rights would be protected. The "if you can't beat them, join them" approach was represented by Trembley's (1977) description of a three-step process of enfranchisement of counseling consumers. He advocated a consumer-counsel or coalition that could exert power and influence for the betterment of human service offerings.

As important as the ideas represented in the previous articles were, none of them specifically suggested that it was the right of clients to select the therapy and therapist that best met their needs. Weinrach and Morgan (1975), however, listed this as a client's right, along with the attendant counselor responsibility to furnish clients with accurate, prior information about available services. In addition, they pointed out that the goals of the consumerism-in-counseling movement and those of counseling itself were the same. Both strive for increased client responsibility and decision making. The legitimacy of client choice was echoed by Coyne and Widiger (1978, p. 707): "A participant's choice of therapist and particular therapeutic approach is a legitimate expression of who that patient is and what he or she wishes to become."

An interesting example of a printed consumer's guide to mental health services is represented by Adams and Orgel's Through the Mental Health Maze (1975). It is predicated on the idea that given accurate prior information about available treatment options, clients can make effective decisions concerning their own therapy. A less detailed guide, but one that also lends credence to the notion of the client as consumer, is the Department of Health, Education, and Welfare brochure

entitled A Consumer's Guide to Mental Health Services (1975). Since therapy is often a new and therefore unknown situation for many clients, especially groups that have historically been denied power, for example women and racial groups (Hare-Mustin et al., 1979), publications such as these may help to substantially reduce the feelings of fear, hesitation, and powerlessness with which many clients approach therapy.

Finally, a study by Leviton (1977) demonstrated one way in which consumerism-in-counseling can actually operate. High school students were asked to evaluate their school's guidance services. Their responses indicated areas in which the counselors needed to concentrate their efforts and suggested directions for program development. Services thus became responsive to consumer needs and desires.

Summary

The preceding articles can be integrated and summarized by listing the main findings and trends. These findings point to the importance and feasibility of investigating client selection of counselor as an alternative method of matching for therapeutic gain.

1. The notion that certain client-therapist pairings enhance the therapeutic process has received consistent support in the research literature.
2. The matching of clients and therapists to optimize therapeutic gain is complicated by the complexity and number of factors involved: client variables, therapist variables, technique and orientation variables.

3. Most attempts to match client and therapist have assumed that the therapist or agency should determine the match.
4. To date, no single method of matching has been demonstrated to be both effective and practical enough to be used extensively.
5. Recognition of the social, interactive aspects of therapy led to attempts to increase client and therapist role complementarity. Many of these client role induction methods were demonstrated to have positive effects on the outcome of therapy.
6. However, an alternative approach to matching was suggested by the extensive literature demonstrating that clients have definite preferences regarding therapists and therapy orientations. These preferences could be the basis of matching.
7. A simple extension of the idea of using client preferences to match clients with therapist or therapy would be to allow clients to match themselves using prior, accurate information about available treatment options.
8. Client selection already operates in the t-group field. The same could occur in individual counseling.
9. Client selection of therapist is coincident with the demands of a growing consumerism-in-counseling movement.
10. There are some suggestions that client selection would have positive effects on both the process and outcome of therapy: choosing may enhance a client's commitment to change; chosen

therapists may themselves be more committed to working with clients who have chosen them and experience greater job and personal satisfaction with their work.

Review of Research on Client Choice of Therapist

Not surprisingly, there has been little research designed to investigate the effects of client choice on the therapeutic process. For example, a report by Nuttey (1969) described a treatment program at the Mendocino State Hospital in California that allowed and encouraged patients to choose their own therapist and therapy. While it was reported that the program resulted in less patient resistance to treatment and higher treatment involvement, no systematic evaluation of the program was done. Since the notion of client choice of therapist runs counter to existing practice in most mental health agencies, and since the necessity of supplying clients with accurate information with which to make a reasoned choice might be threatening to many therapists, it is not surprising that eleven of the twelve studies involving individual counseling situations reviewed in this section were analogue studies.

This section begins with a review of several studies involving the effect of choice on learning outcome in educational settings. While obviously not generalizable to individual therapy situations, the results at least suggest that under some conditions with some subjects choice can influence outcome. Next, seven studies of individual therapy in which prior information about a treatment condition influenced either the subjects' actual choice of treatment or their

expectations regarding therapy are discussed. Finally, five studies that have more direct relevance to the question of client choice of therapist and the implications of that choice for therapy are reviewed in greater detail.

Clifford (1975) investigated both the affective and cognitive aspects of choice in an educational setting by having a teacher assign study booklets to one randomly selected group of students while allowing a second group to select their own booklet. Both groups were tested for learning and task liking immediately following a study period and again after a two week interval. Results indicated that choice of booklet actually resulted in lower learning and retention scores while there was no difference between the two grups in terms of task liking.

Another educational study (Giffel, 1977) compared the effects of assignment versus choice of instructional mode using nurses undergoing in-service training. Results indicated that: (a) there was no significant difference in attitudes toward the mode of instruction between the choice or assigned groups; (b) there were no significant learning differences between the choice and assigned groups.

While seemingly contrary to the idea that choice impacts outcome, the results of these two studies cannot be generalized to a therapy situation. It is possible that in these studies students exercised choice in something that held little importance or meaning for them. Moreover, in Clifford's study, allowing choice might have implied that the teachers cared less about the outcome. For most clients entering therapy, matters of choice would most certainly hold greater urgency

and importance.

Several studies have found that choice in learning situations can have a positive effect on learning. For example, Berk (1976) found that grade school children who were given a choice of group versus individualized instruction methods showed greater sight vocabulary learning than an assigned group. Myrow (1973), in an interesting study on the effect of choice of study topic with high school students, found that while there was no difference between the choice and no-choice groups in their retention of study material, the students who were allowed a choice expressed a greater liking for the study materials and spent more time in studying than no-choice students. Again, the results should not be generalized to the therapeutic setting. The foregoing educational studies do suggest, however, that the act of choosing may be a significant variable in influencing performance, but one whose effects are not yet understood.

One final educational study was that of Hunt (1975). He used the term "environmental cafeteria" to describe an approach that allowed students to sample different styles of instruction before expressing a preference for a particular mode. Their choices were compared with what seemed "best" for them based on their measured conceptual learning levels. The findings accorded with the conceptual matching model with only 16% of the low conceptual students choosing high conceptual learning conditions (i.e., discovery learning), and 41% of the high conceptual students choosing the discovery learning situation. Thus, given prior information about existing alternatives, most students were able to match themselves to the predicted "best" mode of instruction.

In a summary of research on the effect of student self-selection of instructional mode on learning, Cronbach and Snow (1977) reported that "the evidence discourages the romantic view that self-selection of the instructional diet pays off" (p. 478). While their conclusion is directly contrary to the central thesis of this research project, there are several important factors that limit the generalizability of their conclusions to individual therapy situations: (a) most choice-of-learning-mode research has been conducted using non-volunteer subects, that is, students who had little choice about being in school or the subjects they were studying; (b) in many learning mode studies subjects may have been exercising choice in matters that held little importance or meaning for them; (c) typical subjects in educational research may differ from therapy subjects in important ways (e.g., age, IQ, SES, mental health). Finally, most of the educational research involved student choice of learning mode rather than of teacher. The central concern of this investigation involves choice of therapist, not therapy style.

The next series of studies reviewed investigated the effects of prior information on choice of or expectations regarding therapy.

Ewing (1977) described a "cafeteria plan" for the treatment of in-patient alcoholics. His plan was aimed at maximizing alcoholics' participation in their own rehabilitation. Stated simply, patients were given the opportunity to see and to sample all available treatments before selecting the one or combination that appealed to them the most. In addition, each alcoholic could choose his own primary therapist or "dry" peer counselor. Treatment choices were reviewed periodically and

new choices made as individuals progressed in the treatment setting. Ewing stated that the plan helped the alcoholic "to see self as a participant in a group endeavor and in the context of being able to choose what appears to him to be the most appetising at the time" (p. 15). Although this plan has been operating for some time, no data regarding success or effectiveness has been reported. The approach, however, has immediate face validity and obvious appeal to therapists concerned with maximizing client choice and responsibility.

Greenberg (1969) and Greenberg, Goldstein, and Perry (1970) have found that information given prior to subjects' exposure to a therapy session can alter their perceptions of that session and make them more attracted to and receptive to the therapist. Both of these studies involved telling subjects that a therapist was either warm or cold prior to their listening to a taped therapy session. Those subjects who were told the therapist was warm were more attracted to the therapist and evaluated that therapist's style more favorably.

Hypothesizing that therapy would be facilitated by interpersonal attraction, Boulware and Holmes (1970) investigated clients' first impressions of therapists and how they affected their receptivity to therapists' influence. Sixty males and 60 females were randomly assigned to each of four groups and shown the faces of four potential therapists. The faces had been judged to be equally likeable and attractive. The therapists were two males and two females, each pair containing one older and one younger therapist. The subjects were asked how much they would like to talk to each therapist if they had a personal problem and a vocational problem. Results showed that a male

therapist was preferred to a female therapist, especially if the problem involved was vocational. In general, older therapists were preferred to younger therapists. The authors suggested that client preferences should be considered when assigning clients to therapists. If such preferences are considered important enough to affect therapy, this would suggest that those clients with strong preferences should choose their own therapist. There is no evidence to suggest that pairings chosen by clients will be therapeutically inferior to therapist assigned pairings.

Greenberg, Goldstein, and Gable (1971) used normal high school students with no previous history of treatment and disturbed adolescents receiving treatment in a residential treatment center to study the effects of prior information on subjects' choice of therapist. The prior information concerned therapist warmth/coldness and therapists' previous histories of personal problems/no personal problems. Subjects were randomly assigned to one of four groups and then given information about the therapist: warm, previous problems; warm, no previous problems; cold, previous problems; cold, no previous problems. Subjects then listened to a 15-minute simulated therapy session judged to be neutral in warmth by 10 judges and rated the therapist. The hypothesis that subjects would be more attracted to a warm therapist with a similar background was supported. This study is similar to earlier reviewed research on client-therapist similarity and again illustrates that prior information can be used to enable clients to assess potential therapists in terms of their own preferences or needs.

A study by Cheney (1975) demonstrated that similarity to therapist

may be of secondary importance to clients when other factors are considered. Seventy-five inmates jailed for public intoxication were given prior information about the attitudes of a psychotherapist: (a) the attitudes were either similar or dissimilar to the inmates', and (b) the attitudes pertained to important (alcoholism) or unimportant issues (general). Subjects then listened to a 15-minute audio tape of a simulated therapy session and rated the therapist. The results showed that problem relevant attitudes were more important in determining a subject's attraction to a therapist than whether the therapist's attitudes were similar to those of the subject's. These results suggested that clients might make choices or express preferences on the basis of other than attraction or superficial similarity. The reason for clients choosing a particular therapist might be as complex a question as "which therapy for which individual under what conditions?". But, how to enable a client to choose a therapist is far easier to operationalize than matching client to therapist and therapy. What is still needed, however, is direct evidence that client choice of counselor does indeed enhance therapeutic outcome.

Gordon (1976) investigated the effects of volunteering for treatment and being able to choose between two treatments on the clients' perceptions of the value and effectiveness of treatment received. Fifteen volunteer and 15 non-volunteer undergraduate psychology students were randomly assigned to choice or no-choice relaxation training groups. The choice subjects were asked to choose between "neuroglandular" and "cardiovascular" audiotaped relaxation treatments. No explanation regarding the two terms was given and in

reality both treatment conditions were exactly the same. The one session treatment consisted of a twenty minute tape. The outcome measures consisted of a number of self-report Likert scales. Results indicated that volunteers who were given a choice of treatment valued the treatment more and reported it to be more effective. "Nonvolunteers were not significantly affected by the subsequent manipulation of choice between treatments" (p. 801). The results were explained in terms of cognitive dissonance theory: a person's subjective evaluation of an experience is partly a function of that person's effort in, investment in, and feelings of responsibility for that experience. The study suggests that for typical mental health center clients (i.e., voluntary clients) the option of choosing their own therapy or therapist may positively affect their assessment of the value and effectiveness of the treatment they receive.

In what was misleadingly labelled a choice of therapist study, Ersner-Hershfield, Abramowitz and Baren (1979) randomly assigned 55 community mental health clinic clients to a choice or attention-control group. When the clients phoned the clinic for an appointment with a therapist, the choice group were read a description of an active therapist style and a reflective therapist style and asked to state a preference. They were then assigned to one of five therapists who had identified him/herself with the preferred style. The attention-control group clients were merely assigned to the next available therapist. Thus, clients were choosing a preferred style rather than a specific therapist. In both groups assignments to therapists were blind; therapists did not know which clients belonged to which group.

The outcome measures (a. initial interview show rate, and b. clients' and therapists' ratings of satisfaction, expectancy and overall change) were administered after the initial interview. Results indicated that 71% of the choice clients versus only 45% of the attention-control clients showed for the first interview ($p < .05$). There were no differences between the groups on the client and therapist rating scales. The authors recognized that a major shortcoming of their study was the failure to collect long-term therapy data. However, even as simple a choice procedure as the one employed in this study seemed to have an important positive impact on client behavior.

The final five studies to be reviewed have a more direct relevance to the question of client choice of therapist. The first is interesting because of its method of presenting prior information about counselors to prospective counselees. The study questioned whether clients, if given a choice, would choose a counselor similar to themselves (Stranges & Riccio, 1970). Three groups of 36 subjects were chosen to represent one of three cultural groups: Blacks (B), Southern Appalachian (S.A.) and Northern White (N.W.). They were given personal information about six counselors, shown a scripted, five minute video-tape of each counselor's interviewing style, and instructed to choose the counselor they would most prefer to work with. The counseling approaches used by all six counselors were judged to be similar. The counselors represented the following racial-cultural groups: B, male and female; S.A., male and female; N.W., male and female. The results indicated that subjects selected counselors of similar racial background. For Blacks this trend was significant at the .01 level and for Whites at the .05 level.

Furthermore, the various cultural groupings preferred the counselors who represented their particular cultural group. Thus, Blacks chose Black counselors and Appalachian Whites chose Appalachian White counselors. Twelve of the 36 Northern White subjects, however, chose Black female counselors. Based on these results the authors made the following recommendation: "Students should be given an opportunity to select the counselor they wish to see. Presently, practices in most educational settings do not afford the counselee this privilege. Students are usually assigned to a counselor by means of grade level" (p. 45). This study's method of giving clients information about counselors and allowing them to choose their therapist would be within the means of most agencies and clinics. In fact, the procedure would be simplified since clinics would not have to control for differences in counselor style as was done in this study. As long as the information given to clients is relevant and accurate, the reasons for their choices are of secondary importance to the question of whether that choice favorably influences counseling outcome.

In a counseling analogue study Ferreira (1975) investigated the effects of client choice of counselor on the client's readiness for counseling. Based on their scores on a self-disclosure questionnaire, sixty volunteer undergraduate subjects were assigned to three experimental groups and a control group according to a stratified-random procedure. The three experimental groups read statements representing the approaches to therapy used by three counselors and selected the one they most preferred to see. The control group was not given a choice. Subjects in the first experimental group were

reinforced for their choices and told they could see their chosen counselor. The second experimental group was simply told they could see their chosen counselor. The third experimental group was told that their counselor was busy and they would be assigned to someone else. In fact, all subjects were randomly assigned to counselors who used the same style. During and after their interviews, data regarding client readiness for counseling was gathered from trained observers, counselors and the clients themselves. Findings revealed no statistical differences among groups on any of the measures used. It was concluded that neither client choice nor expectancy of being paired with a preferred counselor affected client readiness for counseling. While this study seemed to indicate that client choice of counselor per se had little or no effect on the therapeutic process, it did not investigate actual pairings based on choice. It may well be that client choice of counselor impacts counseling only when the actual pairing is made and perhaps then only after a number of therapy sessions. In addition, it might be the case that when prior information about counselors and their style does not match actual counseling practice, the potential impact of client choice on counseling outcome is lost.

The next two studies reviewed are similar in that they investigated the effect of client choice of counselor on client and counselor satisfaction with counseling. The first (Moore, 1976) used seventy-two students from an upper division counselor education course who were randomly assigned to an experimental group or control group. The experimental subjects chose counselors they preferred to see after

viewing a video tape of six counselors interviewing a coached client. In addition, they were asked to indicate the reason for their choice. The control group subjects were randomly assigned to the same six counselors. After an initial interview with counselors, all subjects and counselors completed instruments designed to measure the quality of the interview and client and counselor satisfaction with the interview. Results revealed no significant difference in satisfaction between the two groups. Furthermore, clients' reasons for choice of counselor did not discriminate levels of satisfaction. The most common explanation for choice of counselor was that the counselor appeared to be calm, competent and concerned about the client.

A similar study by Brown (1977) used volunteer MA counseling students to investigate the effect of client choice of counselor on the counseling relationship. Eight choice subjects and eight control group subjects watched the same client being interviewed by eight different therapists (Special Education or Ed.D. degree program students) who used a standardized interviewing format. The choice group then selected the counselor they wished to work with and the control subjects were randomly assigned to a therapist. All subjects had a one hour interview after which both clients and therapists completed the Barrett-Lennard Relationship Inventory. An audio-tape of each interview was made and trained raters rated three three-minute segments of each tape. Scores from both the questionnaire and the tape ratings were analyzed. When client and therapist ratings were analyzed, no differences between groups were found. However, when the trained raters' scores were analyzed, the choice

subjects were rated as having had a significantly more positive relationship with their therapists ($p < .05$). This study has too many shortcomings for the results to be accepted as meaningful; for example, the various raters were using different criteria, outcome was measured after a single interview, and the clients were not actual counseling clients.

While the results of these two studies seemed to suggest that client choice does not positively affect the counseling process, they did not eliminate the possibility of beneficial effects occurring. The subjects did not have real, pressing problems, and counseling outcome cannot be accurately assessed after only one session or by measuring only expressed satisfaction with counseling. Rather, these analogue studies indicated that the effects of client choice need to be tested in vivo over the entire course of therapy.

The final study to be reviewed here more closely approximated a real therapy situation in which clients were given a meaningful choice of therapy based on accurate, prior information. Devine and Fernald's (1973) subjects consisted of 48 volunteer introductory psychology students who had a measured fear of snakes. Thirty-two of the subjects were shown a video-tape of four therapists demonstrating four approaches to treating the fear-of-snakes dependent variable: (a) systematic desensitization, (b) encounter, (c) rational-emotive, and (d) combination of modeling-behavior therapy. Each therapist demonstrated his/her technique for five minutes and explained the approach for another five minutes. After the film, subjects rated their preference for each therapy and were personally interviewed as a check on their ratings.

Subjects were placed in one of three groups (preferred approach, $n = 16$; non-preferred approach, $n = 16$; control group, $n = 16$) and randomly assigned across all four therapies. Each therapy was assigned 12 clients: 4 strongly preferred, 4 strongly opposed, and 4 control subjects. Treatment consisted of two one-hour sessions. A pre- and post-behavioral measure was used to assess changes in subjects' fear of snakes. Results indicated that subjects who were matched with their preferred therapy showed greater improvement than the other two groups ($p < .01$). Interestingly, the choice in this study for some subjects may have been choice of therapist rather than type of therapy. The authors admitted that preferred therapy may have meant preferred therapist and stated that no attempt was made to separate the two. Thus, in a therapy situation involving subjects with real problems who were given a meaningful choice in regard to their own treatment, the effect on outcome was significantly favorable. The authors offered three possible explanations for the results: (a) therapy for choice subjects was successful because they expected it to be so (patient expectation); (b) some therapies are more effective for some clients (therapy-client fit); (c) choice subjects tried harder in therapy in order to justify their choice. Whatever the possible explanation, the results strongly suggest that clients be allowed to select their own therapy and/or therapist.

Conclusion

The few studies reported in the literature are insufficient in number and research rigor to satisfactorily answer the question of the

effect of client choice of therapist on therapy outcome. Only three of the choice studies reviewed were conducted using authentic clients and only one of those attempted to evaluate the effect of choice on outcome (see Devine & Fernald, 1973). The remainder of the choice studies investigated analogue situations. Those that did attempt to evaluate the impact of choice of therapist or therapy style on actual client-therapist interaction failed to demonstrate any satisfaction or outcome differences between choice and no-choice subjects.

Given this meagre research evidence, the apparent failure of choice of instructional mode to favorably impact learning in educational settings, and the evidence suggesting that inducting clients into the patient role can favorably influence therapy outcome, the following statements seem warranted: first, prior information about therapists or therapies can affect a client's perceptions of a therapist, therapy, or agency; second, while it seems reasonable to expect that for some clients in some therapy settings choice of therapist may have some degree of positive impact on therapy outcome, the relationship needs to be demonstrated; third, while it is clear that it is extremely difficult to assess the reasons for clients' choice of a particular therapist or therapy, a procedure for giving clients information about available alternatives and allowing them to choose is well within the means of most helping agencies.

What is necessary is research designed to compare the progress of choice and no-choice clients in actual therapy conducted by actual therapists. This study was such an attempt.

CHAPTER III

MEASURING THERAPEUTIC OUTCOME

Arbuckle (1977) asserted that 30 years of research has failed to define the process of counseling and that the term itself is so amorphous that it is almost meaningless. If this is the case, it becomes easier to understand why so little systematic research on counseling effectiveness exists. Recognizing that there are major problems facing any researcher endeavoring to evaluate the process of therapy, Fiske, Hunt, Luborsky, Orne, Parloff, Reiser, and Tuma (1970) attempted to identify factors that were critical in improving research on the effectiveness of psychotherapy. They offered the following suggestions as means of improving outcome assessment: (a) measurement procedures should be standardized; (b) measures should not be specific to one theoretical orientation; (c) sufficient detail of the operation of measuring should be reported to enable replication; (d) multiple measures of outcome should be used; (e) the times of measurement should be standardized (e.g., before and after treatment); (f) outcome for each client should be assessed in terms of client-specific goals or target symptoms; and (g) negative as well as positive outcomes should be reported. While not exhaustive, this list can serve as a useful guide in planning outcome research.

Keeping Fiske et al.'s suggestions in mind, the first section of this chapter will briefly review the literature on measurement of therapeutic outcome, the major shortcomings associated with such

measurement, and the specific recommendations (in addition to those listed above) made in response to those shortcomings. The second section will utilize the findings of section one in outlining a procedure for measuring therapeutic outcome in the present study.

Review of Literature on the Measurement of Therapeutic Outcome

In an extensive review of outcome literature, Luborsky, Chandler, Auerbach, Cohen, and Bachrach (1971) found that approximately 60% of the published studies on outcome in psychotherapy used a single criterion: therapists' ratings of clients' improvement. Garfield, Praeger, and Bergin (1971) determined that the second most frequently used criterion was client self-reports of improvement. Both criteria are subjective and assess therapeutic outcome from a single perspective. In the case of client ratings of outcome, it was suggested that the accuracy of such reports is influenced by clients' needs to please their therapist and rationalize their investment of time and money in therapy (Garfield et al., 1971).

Research relying on a single outcome criterion is limited in several ways. Since the process of therapy involves complex, judgemental variables, it is erroneous to select one criterion to represent the entire process of therapeutic change (Bergin & Lambert, 1978; Fiske, 1975; Kiesler, 1971). Furthermore, therapeutic change is not uniform across all patients and all problems (Bergin, 1971). Finally, it should be remembered that raters (client, therapist, expert judge) use different material in making their judgements and that these judgements will be affected by the rater's relationship to the client

(Fiske, 1975).

Obviously, one alternative to using single criterion measures is to assess therapeutic change from more than one perspective. Hadley and Strupp (1977) and Strupp (1978) suggested that researchers consider the three perspectives on outcome represented by patient, mental health professional (usually the therapist), and society, or significant persons in the patient's life. By combining all three evaluations a more meaningful composite of therapeutic change will be achieved. They warned, however, that since each rater has a unique perspective, there may not be high inter-rater agreement.

Similarly, Krause (1969) identified four perspectives, or "publics", based on the idea that since outcome evaluation is always done for someone, it should be done in terms of that person's, or public's, values. The four publics are: (a) patients--persons receiving therapy; (b) clients--persons whose complaints will be remedied by therapy; (c) therapists--those who perform or deliver therapy; and (d) sponsors--those whose planning and material support make therapy possible. Krause suggested that measurement instruments be developed specifically for each public.

While utilizing multiple perspectives in evaluation research has a certain face validity, it is not without problems. There is strong evidence suggesting that there is little agreement among different raters about the extent of progress in therapy (Fiske, 1975; Garfield et al., 1971; Gurman, 1977; Horenstein, Houston, & Holmes, 1973; Margolis, Sorenson, & Galano, 1977; Sloane, Staples, Cristol, Yorkston, & Whipple, 1975). As Fiske (1975) pointed out, high agreement will not

be obtained when the different raters are using different material in making their judgements. This obviously complicates the interpretation of results. In general, it has been found that those involved in the therapeutic process (clients and therapists) tend to give more positive assessments of outcome, probably to justify their involvement (Garfield et al., 1971; Harty & Horowitz, 1976). Some researchers have determined that therapists' ratings deviate most from those of other raters, and that clients' ratings of outcome are more consistent with those of independent judges than they are with therapists' ratings (Gomes-Schwartz, Hadley, & Strupp, 1978; Margolis et al., 1977; Sloane et al., 1975). Thus, the role or status of those rating the process of therapy and their involvement in it must be considered when interpreting the overall results.

In addition to using multiple raters, each having a different perspective on the process of change, a number of writers have suggested using multiple criteria of change and appropriate instruments to measure those criteria (Bergin, 1971; Fiske, 1977; Howard & Orkinsky, 1972; Kiesler, 1971). Bergin, for example, suggested that since "the process of therapeutic change in patients is multi-factorial" (p. 258), researchers should specify the kinds of change they expect for each client rather than rely on uniform, global ratings of change for all clients under all therapeutic conditions. Others have suggested using process as well as outcome criteria (Kiesler, 1971), the patient's functioning in social and wider cultural contexts (Howard & Orlinsky, 1972), and patient-specific behaviours, attitudes and symptoms (Fiske, 1977).

However, when outcome criteria include such complex and diverse variables, high inter-variable correlations will be lacking (Fiske, 1975; Garfield et al., 1971). In fact, as Fiske (1977) puts it, "the crucial consequence of distinctiveness among outcome measures is that they are not interchangeable" (p. 27). Thus, while employing multiple criteria will contribute to a more meaningful composite of therapeutic change for an individual client, the generalizability of the results may be severely restricted.

In summary, even though there will be low agreement among measures and raters which will cause ditficulties in interpreting results, using multiple criteria is preferable to using single criteria in gaining a meaningful understanding of the process of therapeutic change. Strupp and Hadley (1977) offered theoretical support for this conclusion, and Farnsworth, Lewis, and Walsh (1971) reported that there was substantial research evidence to suggest that outcome measures be multiple, non-global, both objective and subjective, free from therapists' theoretical biases, and that both immediate changes and the persistence of those changes be assessed. Thus, outcome research should use multiple raters (patients, therapists, expert judges, significant others in client's social context) and multiple change criteria assessed by appropriate measurement techniques.

Measurement of Outcome in the Present Study

This section presents a rationale for and outline of the means for measuring therapeutic outcome in the present study.

A number of practical considerations limited the kinds of outcome

criteria and measures that could be employed. Since the research was conducted in an urban community mental health clinic, both the procedure for measuring outcome and the criteria measured had to be as brief, simple, nonobtrusive, and nondisruptive to the clinic's provision of services as possible. Also, since the clinic's typical client tended to be voluntary, self-referred, and fee-paying, any procedure that even slightly decreased client patronage would have been unacceptable.

With these limitations and restrictions in mind, it was decided to assess outcome using the following measures:

(1) number of sessions

(2) type of termination

(3) client-specific target behaviors (pre- and posttherapy ratings by both client and therapist)

(4) client self-report of general well-being as measured by the General Well-Being Scale (see Fazio, 1977)

(5) therapist's estimate of client's overall improvement using the Current Adjustment Rating Scale (Truax, 1968)

(6) therapist's satisfaction with therapy.

In addition, all clients were asked their initial reaction to the Center; those in the group that was allowed to choose their own therapists were asked about their reactions to choosing and the reasons for their choice of therapist.

Number of sessions. Garfield's summary (1971) of studies on early termination of therapy determined that most clinics have unplanned-for early terminators. This phenomenon was viewed as a problem and many attempts have been made to identify those variables associated with

early termination. Garfield's statement that "it would appear that the client's expectancies concerning psychotherapy are of some importance for both therapy continuation and outcome, and that explicit attention should be given to them at the beginning of therapy" (p. 289) suggests that length of treatment and outcome may be directly related. Using self-addressed, stamped postcards to assess consumer satisfaction with clinic services, Frank, Salzman, and Fergus (1977) found that community mental health clinic clients who returned the postcards tended to be clients who had stayed longest in therapy. There was a significant positive correlation between length of therapy and expressed satisfaction. An early review of literature by Meltzoff and Kornreich (1970) found there to be a slight positive relationship between the total number of interviews and favorable therapeutic outcome.

A more recent study comparing 44 "unimproved" clients matched with 44 clients rated as "improved" following therapy (Schneller, Schneller, & Saccuzzo, 1977) found only two variables that significantly differentiated the two groups: number of interviews and the type of therapy received. Therapists rated patients as improved when they received six or more sessions of therapy ($p < .005$), and when they received individual plus other types of therapy ($p < .001$).

On the other hand, articles by Hornstra, Lubin, Lewis and Willis (1972) and Littlepage, Kosloski, Schnelle, McNees, and Grendrich (1976) suggested that early termination may not be the problem previously thought. Hornstra et al., after reviewing the records of 611 applicants to a comprehensive community health center during a five month period, found that only 15.2% of the total made "high" use of the services

(more than three "kept" appointments). They discovered that most clients desired "talk as needed" and medication, not extended treatment. However, it was also noted that clients had a poor knowledge of available treatment programs. Thus, while it might well be the case that many clients have little desire for extended therapy, increasing their awareness of available treatment programs and services may help to forestall or eliminate early termination.

In general, then, there is some evidence to support using number of sessions as an indicator of therapeutic outcome. A recent review of 33 studies addressing the question of length of treatment (Orlinsky & Howard, 1978) determined that "a substantial majority of these studies found some significant positive association between amount of treatment and therapeutic benefit. The balance in favor of this finding is clearer when number of sessions rather than total duration is used" (p. 313). Furthermore, because it is easily recorded, objective, and allows for direct comparisons among all clients, number of sessions will be used in this study.

Type of termination. Fiester (1979) reported that mental health clinic clients who themselves chose to terminate reported lower goal attainment than those whose decision to terminate was the result of mutual agreement with their therapists. "This finding adds a further shred of evidence that the manner of termination (clients' decision vs. therapists' decision), as opposed to length of treatment, may be the predominant correlate of either therapist and/or client reported improvement" (p. 186). Thus, in the present study type of termination

will be used as an indicator of outcome. Like length of treatment, it is easily recorded and relatively objective.

Target behaviors. Previously mentioned sources have stressed the need for client-specific outcome goals or criteria (Bergin, 1971; Fiske, 1977; Fiske et al., 1970). A method for generating and evaluating clients' progress in relation to individualized goals, called Goal Attainment Scaling, was reported by Kiresuk and Sherman (1968). The method utilized change scores on individualized client goals while still allowing cross-group comparisons of gains in therapy. While this method was sufficiently reliable, Calsyn and Davidson (1978) reported that client gains scores may not correlate highly with client satisfaction-with-therapy scores. In addition, goal scaling can function not only as an indicator of change, but also as a treatment tool, which is in keeping with Gottman and Markman's (1978) recommendation that "change measures ought to be geared to what it is that a therapeutic program plans to accomplish" (p. 43). The activity of specifying desired outcomes may itself help to clarify and initiate the therapeutic process.

Brattle, Imber, Hoehn-Saric, Stone, Nash, and Frank (1966) and Sloane et al. (1975) reported a similar means by which target behaviors for individual clients were identified and used as indicators of therapeutic change. Brattle et al., for example, asked clients early in therapy (usually within the initial session) to indicate three problems they most wanted help with in therapy. Both client and therapist then rated the severity or seriousness of that problem on a

five point scale. Four months later the three target behaviors were read again and each client and therapist re-rated the severity of the problem. Target behaviour improvement scores for individuals or groups were then analyzed and compared. Brattle et al. (1966) found that target behaviour ratings correlated significantly with other outcome measures (client rating of overall improvement and therapist rating of overall improvement). Inter-rater agreement on the target behaviors can be enhanced by making the target symptoms more behaviorally specific (Fiske, 1975).

Use of a similar method of target behavior identification and rating was used in this study. Thus, assessment of outcome was enhanced by having a client-specific, pre- and posttherapy measure that was simple and easy to understand, and one which reduced the positive transference or halo effect by having both client and therapist to rate specific problems rather than global concepts.

Client self-report of general well-being. Historically there have always been numerous reasons for the lack of interest in client self-report measures in outcome studies (Magolis et al., 1977): (a) it was thought that only professionals could make accurate judgements of improvement; (b) therapists were skeptical if client reports were favorable (positive transference operating) and assumed clients were resisting if evaluations were unfavorable; (c) cognitive dissonance made most clients evaluate their experience favorably; (d) self report data was not considered rigorous, scientific data; and (e) there was no incentive, financial or otherwise, to monitor client satisfaction.

However, recent developments have begun to change this generally negative attitude to client self-report data. As mental health services move from a medical model to a prevention-oriented model there is no sound reason to assume that the recipients of services are unable to judge the effectiveness of the treatment they receive. Legal precedent (the Community Mental Health Centers Amendments of 1975, PL 94-63) has specified the need for client evaluation if programs are to continue to be funded. Thus, there is legislated incentive to monitor client, or consumer, satisfaction. In doing so, it has become clear that clients can furnish valuable data on long-term treatment benefits and other subjective aspects of treatment, e.g., their expectations, unmet needs, and relationship variables. Finally, there is growing research evidence to suggest that clients can judge therapy outcome accurately.

Sloane et al. (1975) reported that client ratings of outcome were more consistent with the ratings of independent judges than were the ratings of therapists, which deviated most from those of other raters. Similar findings were reported by Margolis et al. (1977). Thus, clients may actually be better evaluators of outcome than therapists, a view similar to that expressed by Horenstein et al. (1973).

Gurman's (1977) review of literature determined that there was very little agreement between clients' and therapists' ratings of the therapeutic relationship. Therapists tended to see themselves as creating a better relationship than did clients or independent judges. While his review of relationship research failed to show the previously mentioned agreement between client and expert judges when rating

outcome, Gurman, too, emphasized the importance of client self-report data: "it can be tentatively concluded that patients' ratings of the quality of the therapist-patient relationship are at least as powerful as predictors of therapeutic change as nonparticipant judges' ratings and perhaps even somewhat more powerful" (p. 524).

Thus, whether rating the quality of the therapeutic relationship or therapeutic outcome, there is strong evidence to suggest that client self-report data is at least as accurate and valuable as any other source of data and should be used in outcome research. In the present study, client, or consumer, satisfaction data was of great importance to the clinic in which the study was conducted. In this type of mental health consumer situation the client's opinion regarding outcome is the most important one (Coyne, 1978; Hochbaum, 1969; Horenstein et al., 1973; Morrison, 1978).

Numerous examples of client self-report instruments appear in the literature. They range from very simple client ratings of overall improvement using a five point Likert-type scale (Brattle et al., 1966) to more extensive and detailed instruments such as those reported by Blau (1977), Linden, Stone, and Shertzer (1965), and Truax (1968). The client self-report instrument chosen for use in the present study was the General Well-Being Schedule (GWBS) (Dupuy, 1978). The Schedule is described in detail in the Instruments section of Chapter IV.

Therapist's estimate of client's overall improvement. Therapists' ratings of client improvement have been the most frequently used criteria in outcome research (Garfield et al., 1971; Luborsky et al.,

1971). While the limitations of therapist ratings have been widely recognized and documented (Fiske, 1975; Garfield et al., 1971; Sloane et al., 1975), they are still useful in constructing a multi-perspective composite of the effects of therapy on a given client. Therapists' professional expertise and expert judgement make them a valuable source of information in outcome research.

As with client self-report instruments, numerous therapist rating scales have been reported in the literature. The previously mentioned instruments by Berzins et al. (1975), Blau (1977), and Brattle et al. (1975) are examples of scales that can be completed by both client and therapist. Two examples of instruments that are completed by therapists only are Luborsky's 100 point Health-Sickness Rating Scale (1962) and Martin, Sterne, and Karwisch's modified version of the Psychotherapy Evaluation Questionnaire (1976).

The instrument chosen for use in this study was the Current Adjustment Rating Scale (CARS) (Truax, 1968). The Scale is described in detail in the Instruments section of Chapter IV.

Therapist's satisfaction with therapy. It may well be that in therapy situations in which clients and therapists are matched by clients choosing their therapists, there will be benefits other than the hoped-for changes in client functioning. For example, Palmer (1973) described a successful method of matching juvenile delinquents and correctional workers that resulted in favorable outcomes for both clients and therapists. Those therapists who were matched with youths reported higher job satisfaction and stayed in the job longer than unmatched therapists. It is possible that there may be similar unplanned-for

benefits for therapists working under the system of matching outlined in the proposed study. Lazare, Cohen, Jacobsen, Williams, Mignone, and Zisook (1972) reported that treating client requests as legitimate consumer demands resulted in "increased morale amongst the therapists in our clinic" (p. 882). The obvious importance of these secondary outcomes warrants assessing therapist satisfaction with the therapy situation.

While there are major problems associated with research on counseling effectiveness, there is general agreement regarding the use of multiple raters and outcome criteria to measure therapeutic change. In the present study six indicators of therapeutic change were used. These criteria and the procedures used to assess them satisfied the multiple criteria recommendation and most of the other recommendations listed earlier (Farnsworth et al., 1971; Fiske et al., 1970).

In addition, the chosen criteria and procedures satisfy certain other recommendations. Measures specific to any one theoretical orientation have not been used. Sufficient details of the criteria and instruments are reported to allow replication. Criteria include both global indicators (e.g., satisfaction, general well-being) and more specific indicators (e.g., type of termination, target behaviors). Assessment includes both subjective and objective data.

Two important recommendations have not been fulfilled: the use of expert judges to rate therapeutic change, and the assessment of the persistence of improvement over time. Expert judges were not used for the following reasons: the use of judges would have jeopardized

confidentiality of client information and imposed unacceptable time and scheduling demands on clinic staff. In addition, Gurman (1977) suggested in his review of the literature that clients' ratings of the therapeutic relationship were probably more powerful predictors of outcome than expert judges' ratings.

Persistence of client change over time was not rated because of time limitations. Also, since this study was exploratory in the sense that so few other studies have investigated the same question (and most of those have used analogue as opposed to actual therapy situations), immediate effects of client choice of therapist on outcome must be demonstrated before persistence of change has any meaning.

CHAPTER IV

METHODOLOGY AND HYPOTHESES

General Statement of Problem

It was the purpose of this study to investigate the effect of client choice of therapist on individual therapy outcome using actual clients undergoing actual therapy. Specifically, the study sought to:

1. Develop a practical, simple procedure that allowed community mental health clients to select the therapist of their choice using prior, accurate information about all of the clinic's therapists.
2. Compare the therapeutic progress and outcome of clients in individual therapy who chose their therapists with clients who were assigned to therapists by means of the clinic's usual procedure (i.e., match determined by the clinic's Clinical Director).

The study was conducted at the W.W. Johnson Life Center, a community mental health center serving the Springfield, Massachusetts catchment area (population 216,750), but drawing most of its clients from the city of Springfield whose population was comprised of approximately 14% Blacks, 10% Hispanics, and 76% Whites. The Center began operating in 1978 and serves clients from a variety of ethnic, cultural and linguistic backgrounds. The equivalent of 11.5 full time professional staff offer four levels of mental health care: prevention

emergency, outpatient, and aftercare services. Services are provided in two languages (Spanish and English) to adults (ages 18-59) and senior citizens (60 years and older).

At the commencement of the study the Center's caseload was 161 and comprised 45% non-whites, 55% whites; 55% females, 45% males; and 5.1% senior citizens. For these same groups the national mean percent for all mental health clinics are: 17% non-white, 83% white; 51% females, 49% males; and 3.5% senior citizens. The median percent of clients served by all Massachusetts clinics is .9% non-white, 99.1% white; 54% females, 46% males; and 4.1% senior citizens. (Figures taken from the publications listed below.)

Clients at the W.W. Johnson Life Center are served by a staff consisting of 43% Blacks, 21% Hispanics, and 36% Whites. This compares with a national mental health clinic average of 14%, 5%, and 79% respectively.

Methodology

Experimental design. The experimental design used in this study was a three group version of an experimental group-control group, pretest-posttest design. After an initial prescreening decision by the intake

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1. Inventory of Comprehensive Community Mental Health Centers (ICCMHC). Survey of findings, 1976. Survey and Reports Branch. National Institute of Mental Health, 1978.

2. Provisional Data on Federally Funded Community Mental Health Centers. Prepared by: Survey and Reports Branch. Division of Biometry and Epidemology, National Institute of Mental Health. May, 1978.

worker as to whether a client was capable of participating in the study, those clients included in the study were randomly assigned to the three groups. Reasons for exclusion included: a. severe mental disturbance, b. severe retardation, c. "Outreach" status, i.e., intake conducted away from the Center. During the intake session the experimental procedure was implemented and pretesting on dependent variables begun. At the time of the first therapy session, usually within a week after the intake session, pretesting was completed. Individual therapy then continued to termination or for three months, whichever occurred first, and was followed by posttesting on all dependent variables.

In order to control for the possible impact of pretherapy information on therapeutic outcome (a type of role induction--see Chapter II) two treatment conditions were used. The first (T_1) gave clients access to information about the Center's therapists but did not allow choice. The second (T_2) provided clients with information about the therapists and allowed them to choose their own therapists.

The design appears in diagram form in Figure 1.

Development of therapist information presentation. To aid clients in choosing a therapist a color slide plus audio-tape presentation containing information about all therapists working at the Center was made. Since the act of choosing a therapist is meaningful only if clients have prior, accurate knowledge about available alternatives, a combined visual and auditory presentation was used to maximize information available to clients.

Figure 1: Three Group, Pretest-Posttest Design

	Control Group: (T_0) no information, no choice; assigned to therapist by Clinical Director	Treatment 1: (T_1) information, no choice; assigned by Clinical Director	Treatment 2: (T_2) information plus choice of therapist
	R	R	R
Intake Session: treatment and pretesting	T_0 - RECENTER GWBS	T_1 - RECENTER GWBS	T_2 - RECENTER GWBS RECHOOSE
First Therapy Session: completion of pretesting; approximately one week after Intake	PPCL PPTH CARS	PPCL PPTH CARS	PPCL PPTH CARS
Therapy	X	X	X
Posttesting: at the end of therapy or three months after intake, whichever occur first	GWBS PPCL PPTH CARS SESSIONS THERSAT TERMINATION	GWBS PPCL PPTH CARS SESSIONS THERSAT TERMINATION	GWBS PPCL PPTH CARS SESSIONS THERSAT TERMINATION

R - Self-selected mental health clients randomly assigned to one of three groups.
RECENTER - Reaction to Center Questionnaire.
GWBS - General Well-Being Schedule.
RECHOOSE - Reaction to Choosing Questionnaire.
PPCL - Client Presenting Problems Form.
PPTH - Therapist Presenting Problems Form.
CARS - Current Adjustment Rating Scale.
SESSIONS - Total number of therapy sessions.
THERSAT - Therapists' satisfaction with therapy.
TERMINATION - Type of termination.

Visual cues thus included such things as physical appearance, dress, office decoration and arrangement, and posture, while auditory information included professional and personal material, and voice cues such as accent, speed and volume.

Each therapist was required to audio-tape a personal message or description of his or her approach to therapy and to select at least three color slides to be shown with the audio-tape.

Prior to making their audio-tapes, therapists discussed with the Clinical Director the qualities clients might look for in a therapist. Three possible client concerns were identified: (a) competence (Can he/she help me?), (b) commitment (Will he/she help me?), (c) values (Do his/her values match mine?). Combining these three concerns with their own perceived strengths and competencies, therapists then scripted a personal statement and audio-taped a final version of it. Each therapist was instructed to limit the length of his/her message to 120 seconds. With eight therapists it was important that the overall length of the presentation was kept as short as possible to prevent fatigue or boredom in clients listening to it. A master tape of all eight therapist messages was then constructed with the order of presentation randomized. A verbatim transcript of each therapist's message appears in Appendix A.

For the visual portion of the presentation five to ten color slides were taken of each of the eight therapists. Each therapist then selected a minimum of three for inclusion in the presentation. Three was established as a minimum number to insure that clients were given some variety of visual information about each therapist.

Therapists devised their own poses and background arrangements for the photos. The slides were intended to show the therapists in typical working, caring and welcoming postures. While some therapists paid more attention to constructing background and postural details than others, in every case it was the therapist who decided which photos would be included in the presentation. Typical poses included greeting someone, talking on the phone, sitting at a desk, and interviewing using an "attending" posture. Slides were taken with a Kodak Instamatic X-35 camera using a Kodak Ektron Electronic Flash Unit. Processing was done commercially.

Slides and tape recorded messages were combined by having therapists indicate both the sequence and precise placement of their slides in relation to their messages. At the beginning of the tape and during the 10 second pause between each therapist message there appeared a standard "Welcome to the W.W. Johnson Life Center" slide. After the last therapist's message, a slide with the words "The End" appeared. Thus, the entire presentation consisted of 44 slides, 36 of which were of therapists, and an audio-tape that lasted 13 minutes and 35 seconds. Table 1 shows the number of slides and length of taped message for each therapist.

The therapist messages were recorded on a cassette tape that also included the standard 1000Hz control pulses that provided for automatic sound/slide synchronization. Two copies of the presentation were used in the study to allow for more than one client to be processed at a time. The presentation was shown to the T_1 and T_2 groups using a television-sized Kodak sound/slide projector which advanced slides

Table 1

Therapist Slide Plus Audio-tape Presentations

Therapist	Number of slides	Length of audio-tape message in seconds
A	5	105
B	7	85
C	6	90
D	3	130
E	4	95
F	4	85
G	4	80
H	3	75
	$\bar{x}$ 4.5	$\bar{x}$ 93
	sd = 1.41	sd = 17.5

automatically and in sequence in response to the cassette tape with recorded control pulses. The two projectors were located in a room off the main reception area and clients used headphones to listen to the presentation. Thus, each client was free from distractions while listening to the presentation and the number of clients who were aware of the presentation and its content could be controlled.

Subjects. Potential subjects included all clients who voluntarily sought or were referred for services at the W.W. Johnson Life Center between September 24, 1979, and November 21, 1979. During that time 87 clients were given intake assessments. However, 18 of the 87 were deemed incapable of participating in the study procedure by the Intake Counselor. Reasons for exclusion were:

Outreach status (intake assessment done away from the Center)	7
Intake session done by telephone	1
Refused to participate in procedure	1
Mentally retarded	2
Too heavily medicated	1
Reason not recorded	6
	18

Of the remaining 69 clients who were initially included in the study, 27 had to be excluded from the final analysis. Of these, 24 were excluded because complete pretherapy and/or posttherapy data was unable to be obtained, the most frequent reasons being that the client had terminated contact with the Center and either did not respond to subsequent attempts to reinvolve them or could not be located. Two clients refused to complete the follow-up forms and one was "too psychotic" to complete the posttherapy forms.

Thus, a total of 42 clients, or 48% of the 87 new intakes, were included in the study. While this may seem a high attrition rate, it is inflated by the 18 who were not capable of taking part in the study. Thus, the 42 represented 61% of the 69 clients actually judged to be capable of participating in the study procedure.

All clients were randomly assigned to one of the three groups: Controls (T_0), Treatment 1 (T_1), Treatment 2 (T_2). At the commencement of the study there were 23 subjects in each group (total = 69). However, after the exclusion of the 27 with missing data, 14 subjects

were left in each group (total = 42; see Table 2).

Table 2

Subjects

	Commenced study	Drop-outs	In final analysis
Control group	23	9	14
Treatment 1	23	9	14
Treatment 2	23	9	14
	69	27	42

While it was impossible to randomly select clients from the entire population of potential clients served by the Center, random assignment to groups can be regarded as random sampling, and, therefore, it could be assumed that the groups would be approximately equal across all possible independent variables (Kerlinger, 1973). However, Luborsky, Singer, and Luborsky (1975) argued that this assumption is risky and that even randomly assigned groups should be checked for comparability. Thus, the 18 clients deemed incapable of participating, the 27 drop-outs, and the 42 clients in the final analysis were compared on nine independent variables. Results are presented in Tables 3-10. For all dichotomous variables, independent samples chi-square tests were used to determine whether observed frequencies for groups were significantly different from what could be expected by chance. The .05 level of significance was used to evaluate the χ^2 value. Original data categories for race, presenting problem, duration of problem, marital status and education had to be combined to meet the requirement that "...fewer than 20 per cent of the cells have an expected frequency of

less than 1" (Siegel, 1956, p. 110). As can be seen in the tables, none of the chi-square values was significant.

Table 3

2×3 Contingency Table for Sex by Group

	Unsuitable for study (n=18)	Study Drop-outs (n=27)	In Study (n=42)
Male	8	11	21
Female	10	16	21

$\chi^2 = .589$, df = 2, p = .745

Table 4

2×3 Contingency Table for Race by Group

	Unsuitable	Drop-outs	In Study
White	8	16	23
Nonwhite	10	11	18

$\chi^2 = 1.022$, df = 2, p = .599

Number of missing observations = 1

Table 5

2×3 Contingency Table for Type of Presenting Problem by Group

	Unsuitable	Drop-outs	In Study
Self	14	23	32
Other (home, school, community, work)	3	4	9

$\chi^2 = .562$, df = 2, p = .755

Number of missing observations = 2

Table 6

2×3 Contingency Table for Duration of Problem by Group

	Unsuitable	Drop-outs	In Study
< 6 months	4	12	14
> 6 months	12	14	23

$\chi^2 = 1.882$, $\underline{df} = 2$, $\underline{p} = .390$

Number of missing observations = 8

Table 7

2×3 Contingency Table for Previous Mental Treatment by Group

	Unsuitable	Drop-outs	In Study
Previous treatment	12	14	28
No previous treatment	5	12	14

$\chi^2 = 1.596$, $\underline{df} = 2$, $\underline{p} = .450$

Number of missing observations = 2

Table 8

3×3 Contingency Table for Marital Status by Group

	Unsuitable	Drop-outs	In Study
Married	5	5	10
Single	7	12	23
Divorced, separated, widow/widower	6	10	9

$\chi^2 = 2.764$, $\underline{df} = 4$, $\underline{p} = .598$

Table 9

3×3 Contingency Table for Level of Education by Group

	Unsuitable	Drop-outs	In Study
< Grade 12	9	9	14
Grade 12	3	12	14
> Grade 12	3	4	13

$\chi^2 = 5.803$, $df = 4$, $p = .214$

Number of missing observations = 6

Table 10

2×3 Contingency Table for Presently Employed by Group

	Unsuitable	Drop-outs	In Study
Employed	3	8	7
Not employed	15	19	31

$\chi^2 = 1.509$, $df = 2$, $p = .470$

Number of missing observations = 4

For the continuous variable age, a one-way analysis of variance (ANOVA) was used to test for differences among the means of the three groups. The assumption of equal variances was first tested by calculating Cochran's C statistic (Winer, 1971, p. 208). Cochran's test is relatively simple and adequate for most cases in which the purpose is to insure that large departures from the assumption of equal variances have not occurred. A .05 level of significance was used to test the C statistic. Since the calculated C value was .467 with a corresponding $p = .11$, the assumption of homogeneity of variance was accepted.

The results of the ANOVA are presented in Table 11 and show significant differences among the groups' mean ages. In order to determine how the three groups differed, Sheffe's multiple comparison method was used (Fergusson, 1976). This relatively conservative test adjusts the level of significance to reduce the influence of chance due to having more than just one comparison. The results, shown in Table 12, indicated that the mean age of the 18 Unsuitable clients was significantly higher than that of the 42 In Study clients.

Table 11

Analysis of Variance of Groups' Ages

Source	Sum of Squares	df	Mean Squares	F
Between Groups	1043.05	2	521.53	3.274*
Within Groups	13221.97	83	159.30	
Total	14265.02	85		

*$p = .043$, significant

Table 12

Results of Sheffe's Test of the Age Means of the Three Groups

	Means	Unsuitable 37.58	Drop-outs 31.59	In Study 28.33
Unsuitable	37.58		2.36	6.24*
Drop-outs	31.59			1.09
In Study	28.33			

*Since $F > F'$ $(6.24 > 6.20)$, $p < .05$, significant

It should be noted that while the Unsuitable clients were older and tended to be less educated than the other two groups (see Table 9), the Drop-out clients and the In Study clients, all of whom were randomly assigned to groups, did not differ significantly on any of the nine independent variables tested.

A further comparison of the 27 Drop-out clients and the 42 In Study clients was carried out by comparing the two groups' mean pre-therapy scores on the four outcome measures (General Well-Being Schedule, Presenting Problems--Client, Presenting Problems--Therapist, and Current Adjustment Rating Scale) and their Reaction to Center scores. A one-way multivariate analysis of covariance (MANOVA) was used to test all five variables simultaneously. This procedure takes into account the fact that the scores are probably intercorrelated in some unknown way, and in this case was used to test the assumption that the group means for all five variables would be the same. The group means and standard deviations are set out in Table 13.

Table 13

Group Means and Standard Deviations on Pretherapy Measures

		PREGWBS	PREPPCL	PREPPTH	PRECARS	RECENTER
Drop-outs, n = 27	$\bar{x}$	40.22	12.48	11.22	64.11	21.89
	sd	21.08	2.08	1.50	11.71	8.74
In Study, n = 42	$\bar{x}$	49.02	11.60	11.74	60.60	23.76
	sd	23.65	2.06	1.85	18.63	7.70

Using an alpha level of .05 the multivariate F was found to be not significant ($F = 2.100$, $df = 5/63$, $p < .077$) and the assumption of equal

group means was therefore accepted. Thus, neither differences in pre-therapy adjustment/well-being/problem severity nor initial reaction to the Center accounted for 27 clients failing to provide posttherapy data.

Since dropping out could have been associated with particular therapists, the number of drop-out clients per therapist, the total number of clients seen by each therapist, and the percentage of drop-outs per therapist were compared. The number of drop-outs per therapist excludes the eight clients who did not show for therapy and therefore never met their assigned or chosen therapist. The numbers are set out in Table 14. No statistical analysis was performed. From inspection of the data there does not seem to be any positive association between study drop-outs and any particular therapist(s).

Table 14

Drop-out Clients per Therapist

Therapist	Drop-out clients (at least one session with therapist)	Total clients seen	% of Drop-outs
A	2	12	17
B	3	12	25
C	5	21	24
D	1	2	50
E	3	9	33
F	4	10	40
G	0	0	0
H	1	3	33
	$\underline{n}$ = 19	$\underline{n}$ = 69	

The 42 clients for whom complete pre- and posttherapy data was obtained consisted of 14 T_0 subjects, 14 T_1 subjects and 14 T_2 subjects. To check that these three groups were approximately equal across all independent variables--even though randomly assigned to groups--independent samples chi-square tests were carried out for the eight dichotomous variables. Results are presented in Tables 15-22. The .05 level of significance was used to evaluate the χ^2 values. For five of the variables (presenting problem, duration of problem, marital status, education, and employment status) more than 20% of the expected cell frequencies were less than five, causing the χ^2 statistic to be inflated. However, since even these inflated χ^2 values were not significant, no correction procedure was carried out.

Table 15

2×3 Contingency Table for Sex by Group

	T_0	T_1	T_2
Male	8	6	7
Female	6	8	7

$\chi^2 = .571$, $\underline{df} = 2$, $\underline{p} < .752$

Table 16

2×3 Contingency Table for Race by Group

	T_0	T_1	T_2
White	8	7	8
Nonwhite	6	6	6

$\chi^2 = .039$, $\underline{df} = 2$, $\underline{p} = .981$

Number of missing observations = 1

Table 17

2×3 Contingency Table for Type of Presenting Problem by Group

	T_0	T_1	T_2
Self	11	10	11
Other (home, school, community, work	3	3	3

$\chi^2 = .014$, $\underline{df} = 2$, $\underline{p} = .993$

Number of missing observations = 1

Table 18

2×3 Contingency Table for Duration of Problem by Group

	T_0	T_1	T_2
< 6 months	6	1	7
> 6 months	7	9	7

$\chi^2 = 4.557$, $\underline{df} = 2$, $\underline{p} = .102$

Number of missing observations = 5

Table 19

2×3 Contingency Table for Previous Treatment by Group

	T_0	T_1	T_2
Previous treatment	9	10	9
No previous treatment	5	4	5

$\chi^2 = .214$, $\underline{df} = 2$, $\underline{p} = .894$

Table 20

3×3 Contingency Table for Marital Status by Group

	T_0	T_1	T_2
Married	4	1	5
Single	8	7	8
Divorced, separated, widow/widower	2	6	1

$\chi^2 = 7.354$, df = 4, p = .118

Table 21

3×3 Contingency Table for Level of Education by Group

	T_0	T_1	T_2
< Grade 12	6	3	5
Grade 12	5	5	4
> Grade 12	3	5	5

$\chi^2 = 1.721$, df = 4, p = .787

Number of missing observations = 1

Table 22

2×3 Contingency Table for Presently Employed by Group

	T_0	T_1	T_2
Employed	2	3	2
Not Employed	11	10	10

$\chi^2 = .292$, df = 2, p = .864

Number of missing observations = 4

For age, a one-way ANOVA was used to test for differences among the means of the three groups. Mean ages and standard deviations for each group are presented in Table 23.

Table 23

In Study Group Means and Standard Deviations for Age

	$\bar{x}$	sd
T_0	30.36	12.22
T_1	28.71	12.16
T_2	25.93	7.08

Using Cochran's C statistic the assumption of equal variances was first tested (Winer, 1971) and accepted ($C = .430$, $p = .54$). The results of the ANOVA are presented in Table 24. There were no significant differences among the groups' mean ages.

Table 24

Analysis of Variance of In Study Groups' Ages

	Sum of Squares	df	Mean Squares	F
Between groups	140.33	2	70.16	.606*
Within groups	4 513.00	39	115.71	
Total	4653.33	41		

*$p > .05$, not significant

In summary, the 18 clients judged incapable of participating in the research procedure had a higher mean age and tended, though not significantly so, to have less formal education than clients who

participated in the study. The 42 clients included in the final analysis did not differ from the 27 study drop-outs on any of the nine personal history variables tested. Furthermore, the groups were not significantly different in terms of their initial reaction to the center or their pretherapy scores on outcome measures. Thus, the potential problems associated with subject mortality between pretest and posttest do not seem to exist (Huck, Cormier, & Bounds, 1974). Finally, dropping out was not seen to be disproportionately associated with any particular therapist or therapists. None of the available information about the clients accounted for the fact that of the 69 original study subjects 27 failed to provide posttherapy data.

When the T_0, T_1 and T_2 subjects (in each case $n = 14$) were compared on the nine personal history variables, there were again no significant differences.

In terms of external validity, the subjects in the present study are representative of all self-selected or referred clients presenting for treatment at the W.W. Johnson Life Center who are judged to be capable of undergoing the Center's evaluation procedures. This population contains the bulk of the Center's target population. However, since the subjects are not necessarily representative of clients at other mental health clinics, extreme caution must be used when making generalizations.

Therapists. All eight therapists at the Center participated in the study. However, two terminated employment at the Center before the client intake phase of the study was complete. Nevertheless, their

leaving did not significantly affect the progress or results of the study since one's caseload included only two study clients (and the only one of those included in the final 42 clients was successfully terminated) and the other's caseload included none. Information about the therapists is summarized in Table 25.

Table 25

Details of Therapists Participating in Study

Therapist	Sex	Age	Race	Education	Experience (in months)	Theoretical orientation
A	m	37	Black	MS-Clinical Psychology	24	Carkhuff, client center
B	m	27	Hispanic	MA-Psychology	54	client center
C	f	24	White	MA-Human Relations	5	Carkhuff, client center
D	m	30	Black	EdD-in process (Counseling)	84	no data
E	f	23	Hispanic	BSE-Special Education	9	no data
F	m	29	Black	MEd	36	no data
G	f	31	Black	MSW	66	client center
H	m	32	White	MA-Clinical Psychology	120	client center
		$\underline{x}$ = 29.13			$\underline{x}$ = 49.75	
		$\underline{sd}$ = 4.51			$\underline{sd}$ = 39.47	

In general, the staff's racial composition reflected the fact that comparatively large numbers of nonwhite clients made use of the Center's services. Age, level of education and theoretical orientation

It was administered to all clients immediately after their intake evaluation session. Nine of the items had seven point "strongly agree-strongly disagree" response scales while the tenth was an open-ended item asking respondents to list any additional reactions to the Center. A seven point, rather than a five point, scale was used to increase the scale's degree of differentiation (Selltiz, Wrightsman, & Cook, 1976). Positively and negatively worded items were randomly ordered. Scoring consisted of summing the responses for the first nine items. Negatively worded items were scored in reverse. The range of possible scores was 9 to 63. The lower the total score, the more favorable a client's reaction to the Center. Items left blank were given the average score of 4. There were only six such occurrences among the 621 items answered by the 69 clients who were initially included in the study.

Questions assessed clients' feelings about their brief experience at the Center. Item content consisted of three client-involvement-in-therapy items, three client-readiness-for-therapy items and three client-feelings-of-acceptance items. The content of each item was suggested by the literature on client rights and consumerism-in-counseling reviewed in Chapter II.

The questionnaire was reviewed by all therapists and clerical staff at the Center and their comments and suggestions were incorporated in the final version which appears in Appendix B. A timed administration of the questionnaire to one of the clerical staff who was instructed to work "slowly and methodically" indicated that completion could take up to 2½ minutes.

One major criterion in devising and selecting outcome measures was

that they could be read by most of the clients. It could not simply be assumed that all clients would be high school graduates and have a correspondingly high reading ability. Therefore, two means of coping with poor or slow readers were instituted. The first involved producing sound/slide presentations of the pre- and posttherapy instruments. Slides of each questionnaire were made so that there were 4-5 items per slide, in effect enlarging the printed material and making it easier to read. An audio-tape was then made and the sound and slides synchronized by means of recorded control pulses. Clients could then read the printed questionnaires or follow the deliberately slow-paced audio-tape and accompanying slides while completing the questionnaires. Anyone still having difficulty could ask an intake worker for assistance. The number who needed to do so was minimal.

The second means involved insuring that the readability of the instruments was sufficiently easy that even low level readers could handle the material. The reading ease formula selected for measuring readability was the Flesch Reading Ease Formula (Flesch, 1948). In a comprehensive review of existing formulae for determining readability, Klare (1974-1975) described the Flesch method as reliable, valid, easy to use, and one of the most widely used methods in the history of readability measurement. In addition, Powers, Sumner and Kearl (1958) stated that "of popular formulas without word lists, the Flesch formula is statistically best" (p. 104). Reliability of rater to rater scorings using the Flesch formula was very high, even when comparing experienced with inexperienced raters (Hayes, Jenkins, & Walker, 1950). Lest the problem of readability be seen as relatively unimportant, Bournstein

and Johnson (1975) tested the reading ease of client information brochures of nine mental health centers in Chicago. Most of the material tested was beyond the targeted audience's reading level.

Measuring reading ease using the Flesch formula involves counting the number of words in a passage, or a sample, e.g., 100 words, the number of syllables per 100 words, and the average length of sentence. These figures are then inserted into a formula and a reading ease score calculated. The resulting score can then be compared with Flesch's table of reading difficulty:

Flesch Score	Level of Difficulty	School grade equivalent
0-30	very difficult	College
30-50	difficult	High School or some college
50-60	fairly difficult	Some High School
60-70	standard	7th-8th grade
70-80	fairly easy	6th grade
80-90	easy	5th grade
90-100	very easy	4th grade

Flesch (1948) reported a number of validity studies wherein ratings of materials using the formula agreed with ratings made by readers and teachers.

Using the Flesch formula two samples of the RECENTER questionnaire were scored and an average of the two taken. The resulting reading ease score was 86.6, described as "easy, 5th grade" level.

Reaction to Choosing Your Counselor Questionnaire (RECHOOSE). This summated scale questionnaire, also devised for this study, was

administered only to clients who were allowed to choose their therapist. It was completed at the conclusion of their intake evaluation session. It consisted of two parts. The first included 13 items with five point response scales ("very important-very unimportant") asking clients to indicate why they had chosen a particular therapist. An open-ended fourteenth item asked them to list any other counselor qualities that were important to them in making their choice. The items could be categorized as relationship items, directive-therapist items and physical appearance items. Their order in the final version was randomized.

The second part included nine items with five point response scales ("strongly agree-strongly disagree") asking clients to indicate what impact the act of choosing had on them. An open-ended tenth item asked them to list any other effects choosing had on them. Positively and negatively worded items in Part II were randomly ordered.

Scoring for Part I merely involved ranking the counselor qualities in terms of their importance to clients. In Part II the responses for the nine items were summed. Negatively worded items were scored in reverse. The range of possible scores was 9 to 45. The lower the total score, the more positive the act of choosing was judged to be to clients. In both parts of the questionnaire items left blank were given the average score of three. There were 21 such occurrences among the 506 items answered by the 23 original choice-of-therapist subjects included in the study.

The questionnaire was reviewed by all therapists and clerical staff at the Center and their comments and suggestions incorporated in

the final version which appears in Appendix C. A timed administration indicated that completion could take up to 4½ minutes. Using the Flesch formula the questionnaire's Reading Ease scores were calculated by averaging the scores from two 100 word samples: Part I--86.9; Part II--87.7. Both scores are "easy, 5th grade" level.

General Well-Being Schedule (GWBS). The General Well-Being Schedule purports to measure "general psychological well-being", "the net impact of the many forces which affect an individual's subjective emotional or feeling states" (Dupuy, 1978, p. 1). The focus of the schedule is on an individual's inner personal state rather than feelings toward specific external conditions or situations. Construction of the schedule allowed for both quality of (positive or negative) and intensity of affect dimensions.

Eighteen items designed as indicators of general psychological well-being were used. The first 14 items were 6 response option items and items 15-18 were 0 to 10 rating bars. An additional 15 items (criterion-type behavioral and self-evaluation items) were not used in this study. The necessity to limit the disruptiveness and duration of the assessment procedure and Dupuy's suggestion that "results of several analyses [of the 18 items] provided sufficient evidence that a reasonable and strong inference can be made that these indicators can be combined to form an overall index of general well-being (GWBS)" (p. 1) resulted in the decision to use only the first 18 items.

For scoring purposes the responses were assigned ordinal scores from 0 to 5 or 0 to 10. Low scores represented more distress and high scores represented a higher level of well-being. The total score range

was from 0 to 110. The schedule's time frame was "during the last month". Items 1-14 that were left blank were given alternately a three or four while blanks among items 15-18 were given the average score of five. There were 12 blanks among the 1512 items answered by the 42 clients completing both pre- and posttest forms of the questionnaire.

The GWBS was originally developed in 1970 by H. Dupuy for the National Center for Health Statistics and was used in a national American health survey conducted from April, 1971 through October, 1975. A national sample of 6,913 noninstitutionalized adults ages 25-74 were administered the GWBS at 100 different locations. This schedule was one part of a comprehensive 3½ hour medical examination. Findings from that survey included the following:

a. A strong general factor for the 18 items was found using factor analysis.

b. Internal consistency for the 18 items was high ($\underline{r} = .93$).

c. Test-retest reliability after three months yielded coefficients of about .80.

d. The GWBS was found to correlate with certain other mental health tests (Zung, Beck, Langer, MMPI, Lubin, the Symptom Check List-90) as highly as those tests correlated among themselves ($\underline{r} = .5$ to $.7$).

e. Two validation studies revealed that the GWBS successfully discriminated mental health patients from population samples ($\underline{r} = .43$ and $.56$).

f. Analysis of the relationship between other variables and

the GWBS scores allowed a broad categorical description of scores to be made:

GWBS Scores*	Descriptive Attribution	Percent in the U.S. Adult Population
73-110	Positive well-being	71.0
61-72	Moderate distress	15.5
0-60	Severe distress	13.5

* (See Dupuy, 1978, p. 10)

Further support for the validity and utility of the GWBS is found in Fazio's 1977 validation study. In an attempt to compare the GWBS "with several other self-report scales [MMPI, Psychiatric Symptoms Scale, Zung Self-Rating Depression Scale] in terms of their concurrent validity against interviewer ratings of current depression and inter-correlations among these several scales" (p. 1), Fazio tested 195 volunteer university students enrolled in introductory psychology classes once in the fall of 1972 and again in the spring of 1973. He found that:

a. the GWBS successfully differentiated less depressed from more depressed students in the sample.
b. the GWBS scores correlated as highly with the other measures of depression and tension-anxiety as they did among themselves.
c. test-retest reliability using 41 students tested twice, three months apart, yielded a correlation of .851.

Fazio concluded by reporting that "because the GWBS is brief, well designed, and relevant in content, it should be useful in a

variety of research and applied settings" (pp. 12-13), including psychotherapy outcome research.

Like other client instruments used in this study, a sound/slide presentation of the GWBS was made for clients who might experience difficulty in reading it. Three 100 word samples were used to calculate Flesch reading scores. The average of the three was 77.7 which Flesch described as "fairly easy, 6th grade" level. A timed administration of the Schedule indicated that it could take up to 14 minutes to complete. Copies of the pre- and posttherapy forms are included in Appendix D.

In summary, there is strong support for utilizing client self-report data in assessing outcome. The GWBS was chosen for use in this study because of its brevity, simplicity, and reported validity and reliability.

Presenting Problems Rating Forms (PPCL and PPTH). Two identical forms were used, one completed by clients (PPCL) and one by the client's therapist (PPTH). (See Brattle et al., 1976, and Sloane et al., 1975, for examples of similar instruments.) At the beginning of the first therapy session the clients were asked to indicate the three problems they most wanted help with in therapy and to rate the severity of each using a five point scale ("not serious-extremely serious"). At the end of the first therapy session the therapists rated the same three problems using a similar five point scale. Scoring involved summing the ratings for the three problems to get a total presenting problems score. For clients who did not list three problems, the average of the first two was used for the third. Following therapy both client and

therapist re-rated the original three problems using the same five point scale. Scoring was done in the same way as for the pretherapy forms. Copies of all four forms, PPCL pre- and posttherapy, PPTH pre- and posttherapy, are included in Appendix E. A sound/slide presentation of both pre- and posttherapy forms was made for the PPCL forms. A timed administration indicated that the PPCL forms could take up to 3 minutes each to read and complete, longer for the pretherapy form if listing three problems caused some difficulty. The Flesch Reading Ease score for the PPCL form was 82.69, "easy, 5th grade" level.

In summary, assessment of outcome was enhanced by using a simple, client-specific, pre- and posttherapy measure that was completed by both client and therapist.

Current Adjustment Rating Scale (CARS). The CARS, which is based on the Psychiatric Status Schedule, was originally developed for use with adults and could be completed by client, therapist and independent judges. The CARS consists of 14 nine point Likert-type scales which required the respondent to evaluate the client's current functioning, satisfactions and social stimulus value (e.g., likability). The total score range was 14 to 126. The higher a client's total score the more favorable that person's current adjustment. Items left blank were given the average score of 5. There were 47 such occurrences among the 588 items about the 42 clients included in the final data analysis.

In a study designed to examine the problem of intersource consensus in assessing psychotherapeutic outcome, Berzins, Bednar, and Severy (1975) administered the CARS, the Psychiatric Status Schedule, the Minnesota Multiphasic Personality Inventory, and a Q-sort to clients,

therapists, and psychometrists before and after therapy. While the researchers were primarily interested in the problem of intersource consensus, they had the following to say about the CARS: "overall, however, the CARS emerged as the most promising instrument for further exploration, not only because of its strong relationship to all other measures of improvement used in this study but also because of its relative brevity" (p. 18).

The CARS was chosen for use in this study as a pre- and posttherapy therapists' estimate of overall client improvement. Therapists' ratings of client improvement have been the most frequently used criteria in outcome research and the CARS was chosen for its brevity and ease in completing. Since it was completed only by therapists, no Reading Ease score was calculated. Copies of the pre- and posttherapy versions of the CARS are found in Appendix F.

Therapist's Satisfaction with Therapy (THERSAT). Assessment of therapist satisfaction in the present study was accomplished by adding three questions to the posttherapy CARS instrument. They appear as questions 15, 16 and 17 on the posttherapy CARS in Appendix G. The three items were of the same form as the CARS items (i.e., nine point response scales) and asked therapists to indicate (a) their overall satisfaction with help they were able to give, (b) whether they would like to again work with the client, and (c) their overall effectiveness with the client.

Scoring consisted of summing the scores from the three items so that the higher the total score, the more satisfied was the therapist with therapy.

Number of sessions and type of termination. In addition to the specific instruments just described, two other measures were used: number of therapy sessions and type of therapy termination. Number of sessions was merely the total number of therapy sessions each client received. Since each session was recorded in the client's file, the total was easily obtained from the record.

When therapy was terminated, the type of termination was recorded in each client's file as follows: (1) unilateral client decision; (2) mutual client and therapist decision. Any clients who were still in therapy three months after their intake interview were categorized as "mutual" terminators. There were 19 such instances.

Procedure. All walk-in and referred clients first underwent the Center's usual intake evaluation session. Two designated intake counselors conducted all but a few of these sessions. In the event that neither was available, another staff member would put the client through the same, standard intake procedure. It should be noted that the Center adopted the entire research procedure and outcome measures as their normal operating procedure for the duration of the study. Thus, the procedure and instruments were never extra to normal practices. A procedure flowchart can be seen in Appendix H.

The first decision made by the intake worker when seeing a new client concerned the client's ability to participate in the research procedure. Those clients who expressed a preference for a therapist, who were judged to be too disturbed or retarded, who asked not to participate in any phase of the procedure, or who were seen as outreach

clients (i.e., away from the Center) were not included in the research program. Those included in the study were randomly assigned to one of the three groups: Control group--assigned to a therapist by the Clinical Director after regular prescreening/intake contact; Treatment 1--assigned to a therapist by the Clinical Director after viewing the therapist sound/slide presentation; Treatment 2--chose own therapist after seeing the therapist sound/slide presentation.

During the course of the study a number of client irregularities occurred. Two couples referred themselves to the Center for joint therapy. It was decided to treat them as four single subjects, but to include both members of the pairs in the same group. One of these pairs was randomly assigned to the T_2 group. Both declined to choose a therapist after being given the sound/slide presentation. However, since it was the freedom to choose that was thought to be important rather than choosing itself, their decision to have a therapist selected for them was not thought to have any adverse influence on the study's results.

Random assignment was accomplished as follows: packets of the pretherapy rating forms for each group were coded so that A-1 identified the first client as a control group client and B-2 indicated that the second client was to be the first client included in the Treatment 1 group. Similarly, C-3 was the first client included in the Treatment 2 group. Successive packets were numbered in the same way (i.e., A-4, B-5, C-6, A-7, etc.). Thus, when processing a new client, the intake worker would simply take a packet of pretherapy forms off the top of the pile, note the letter (A, B, or C) and process the client accordingly.

Instructions given to the intake worker for dealing with each group of clients were as follows:

TO: INTAKE WORKERS

RE: Intake procedure for new clients

PROCEDURE FOR GROUP A:

1. Follow usual intake procedure.

2. Tell clients the following:

> "Now that your first meeting at the Center is completed, we would like to get your reaction to the Center and how you have been feeling during the last couple of months. To do this we would like you to look at a slide film and complete a couple of forms. I will help you get started. If you have problems, come and tell me. This should not take you any longer than 30 minutes."

3. Have clients view the sound/slide presentation marked "A" and complete the following:

   a. "Reaction to Center"

   b. "General Well-Being Schedule"

4. Assign to therapist in the usual way.

PROCEDURE FOR GROUP B:

1. Usual intake procedure.

2. Tell Group B clients the following:

> "To help you get a better idea about the therapists at the Center--who they are and how they work with people--we would like you to see a slide film they have made. We think it will answer some of your questions about the Center."

3. Have client view therapist slide and tape presentation.

4. Tell clients the following:

> "Now that your first meeting at the Center is completed, we would like to get your reaction to the Center and how you have been feeling during the last couple of months. To do this we would like you to look at a slide film and complete a couple of forms. I will help you get started. If you have problems, come and tell me. This should not take you any longer than 30 minutes."

5. Have client view the sound/slide presentation marked "B" and complete:

   a. "Reaction to Center"

   b. "General Well-Being Schedule"

6. Assign to therapist in the usual way.

PROCEDURE FOR GROUP C:

1. Usual intake procedure.

2. Tell Group C clients the following:

> "To help you get the most out of your time at the Center, we would like you to see a slide film about all the therapists at the Center--who they are and how they work with people. Then we would like you to choose the person you want to have as your therapist."

3. Have client view therapist slide and tape presentation and choose own therapist.

4. Tell client the following:

> "Now that your first meeting at the Center is completed, we would like to get your reaction to the Center and how you have been feeling during the last couple of months. To do this we would like you to look at a slide film and complete three forms. I will help you get started. If you have problems, come and tell me. This should not take you any longer than 40 minutes."

5. Have clients view the sound/slide presentation marked "C" and complete:

   a. "Reaction to Center"

   b. "Reaction to Choosing" (two parts)

   c. "General Well-Being Schedule"

Thus, at the completion of the intake session all clients had completed the RECENTER and GWBS questionnaires and the Treatment 2 clients had completed the RECHOOSE questionnaire as well.

Usually within a week of the intake session a client had been contacted by the assigned or chosen therapist and a first therapy session scheduled. During this first session all therapists followed a standard procedure with all clients. Instructions to therapists were as follows:

1. Before commencing therapy have your client view the sound/slide presentation of the Presenting Problems (pretherapy) form and complete it.
2. Assist any client experiencing difficulty with the form.
3. Collect the completed Presenting Problems form from your client.
4. Include in the first session a review of the problems identified by the client and provide an opportunity for the client to freely explore those problems.
5. After the session, complete your own rating of the severity of the client's expressed problems using the therapist's form of the pretherapy Presenting Problems form.
6. Complete a pretherapy Current Adjustment Rating Scale for your client.

Thus, by the end of the first therapy session all pretherapy testing had been completed.

Each client's listed problems on the pretherapy Presenting Problems form were copied verbatim onto both the client's and the therapist's posttherapy Presenting Problems forms. Then, together with copies of the other posttherapy questionnaires, they were attached to the client's personal file with the following instructions to the therapist in charge:

> Remember to collect posttherapy information from all clients. The following forms need to be completed and will be in the client's file:
>
> 1. Presenting Problems, posttherapy (client's form)
> 2. Presenting Problems, posttherapy (therapist's form)
> 3. Posttherapy Current Adjustment Rating Scale.
>
> WHEN TO COLLECT: At the termination of therapy or 3 months after the date of the intake session, whichever comes first. FOR THIS CLIENT POSTTHERAPY INFORMATION SHOULD BE COLLECTED BY (date three months from intake) .

Specific instructions for the posttherapy data collection session were:

1. Before terminating the session have your client complete his/her posttherapy Presenting Problems form and the General Well-Being Schedule. If it will help your client to complete these forms, have him/her view the sound/slide presentation of these forms.
2. Include in the session a review of where the client was in relation to his/her problems, where he/she is now, and what any changes or lack of changes mean relative to termination.

3. Complete a therapist posttherapy Presenting Problems form.

4. Complete the posttherapy Current Adjustment Rating Scale.

The decision to administer posttherapy questionnaires after three months even if therapy had not been terminated was based on the following: in the 22 months prior to the commencement of this study, the average number of therapy sessions for all clients at the Center was 10.1 with a range of 0 to 59. However, 12% of those clients had 20 or more sessions and thus disproportionately inflated the average. With their data removed the average number of sessions was 6.8 with a standard deviation of 5.3. Since the Center's therapists usually see clients once per week, the three month period was thought to be sufficient time for all but a small percentage of clients to be counseled to termination.

It should also be noted that the pretherapy data collection spanned two sessions, the intake session and the first therapy session. Because of the length of the intake session (60-90 minutes) and the necessity of gathering extensive client background information extra to that needed for this study, the number of pretherapy forms to be completed was limited to the client self-report measure (GWBS) and the RECENTER. The remaining forms (PPCL, PPTH and CARS) were completed during the first therapy session. A feature of the client-specific Presenting Problems form is that it can function as an aid to therapy (Gottman & Markman, 1978) and should therefore be completed in the presence of the client's therapist. The therapist version of the Presenting Problems measure and the CARS could only be completed by the therapist after contact with the client. Since all clients followed

the same procedure, any therapeutic advantages or disadvantages accruing to the split data collection arrangement should be the same for all three groups and thus have negligible effects on the study results.

Hypotheses

One of the purposes of this study was to investigate the effect of choice-of-therapist on therapy outcome. It was decided to use non-directional hypotheses. While some of the client rights literature reviewed in Chapter II suggested that clients should be able to choose a therapist or therapy as of right, evidence for the efficacy of this choice on therapy outcome was almost totally lacking. The small number of relevant studies reported to date suffered methodological shortcomings and generally reported no differences between choice and no-choice clients in terms of satisfaction with or progress in therapy. This lack of research evidence and the possibility expressed by some practising therapists that clients might actually match themselves to avoid solving or confronting their problems led to the decision to frame non-directional hypotheses. The alpha level selected for use in hypothesis testing was .05. Apart from being a conventional and widely used alpha level in psychological research, it represents an acceptable compromise between reducing the occurrence of a type I error (i.e., rejecting the null hypothesis when it should be accepted) and risking the occurrence of a type II error (i.e., accepting the null hypothesis when it should be rejected).

There are two main hypotheses dealing with therapy outcome and

one secondary hypothesis dealing with initial client reaction to the Center in this study.

Hypothesis I. There will be no differences in mean scores among the three treatment groups on the six, continuous, therapy outcome measures:

a. General Well-Being Schedule

b. Presenting Problems--Client

c. Presenting Problems--Therapist

d. Current Adjustment Rating Scale

e. Therapist Satisfaction with Therapy

f. Number of Therapy Sessions

H_0: $M(T_0) = M(T_1) = M(T_2)$ for all six measures

The alternative hypothesis states that there will be treatment differences with respect to the six outcome measures:

H_1: not H_0

Hypothesis II. The proportion of mutually terminated clients (decision by both therapist and client) in each treatment group will be the same.

The alternative hypothesis states that the proportion of mutual terminations will differ from group to group.

Hypothesis III. There will be no difference in mean Reaction to Center scores among the three treatment groups:

H_0: $M(T_0) = M(T_1) = M(T_2)$

The alternative hypothesis states that there will be differences among the treatment groups on mean Reaction to Center scores:

H_1: not H_0

While it is impossible to construct testable hypotheses regarding Reaction to Choosing scores, client information pertaining to choice of therapist and the impact of choosing will be analyzed. In addition, data analyses that clarify or extend the results of formal hypothesis testing will be conducted. Finally, the utility of the procedure for giving clients prior information about therapists is discussed in Chapter VI.

C H A P T E R V

RESULTS

This chapter is divided into three parts: part I describes the computations used in testing the formal hypotheses; part II analyzes the data from the Reaction to Choosing instrument; part III describes additional analyses of the data.

The raw data used in computations is presented in Appendix I along with the correlation matrix for all continuous dependent variables.

Hypothesis Testing

Hypothesis I. There will be no differences in mean scores among the three treatment groups on the six, continuous, therapy outcome measures (GWBS,PPCL,PPTH,CARS,THERSAT,SESSIONS).

In this study directional hypotheses were not used. Thus, the first step in analyzing the data was to establish that some group differences did exist. To do this the overall F statistic was first tested. Only when the overall F is significant will there be some other comparison of group means significant at or beyond the same level (Hays, 1973).

A one-way multivariate analysis of covariance (MANCOVA) with six criteria and four covariates was used to test the null hypothesis. This multivariate test was used since all six variables were obtained from the same subjects and were possibly correlated in some unknown manner. The multivariate procedure simultaneously takes into account

these correlations among the dependent variables, a process not possible using univariate F tests (Huck, Cormier, & Bounds, 1974). Pretest scores on the GWBS, PPCL, PPTH and CARS were used as covariates to reduce the error variance due to initial individual differences. "The covariate[s] need not be the same as the dependent variable[s]. It can be any variable that we have reason to believe will be correlated with the dependent variable" (Edwards, 1979, p. 145). This procedure decreases the within-cell variability of subjects by removing the effects of initial differences in group pretest scores from group posttest scores (Dayton, 1970; Kerlinger, 1973). Unadjusted group means and standard deviations of the variables tested in Hypothesis I are presented in Table 27.

The first step in the covariance analysis is to test the assumption of within-class homogeneous regression coefficients. The assumption could not be met ($F = 2.678$, $df = 24/105.87$, $p < .001$). However, Winer (1971, p. 772) suggested that "there is evidence to indicate that the analysis of covariance is robust with respect to homogeneity assumptions on within-class variances and regression coefficients", and, therefore, the complete analysis was carried out. The multivariate analysis of covariance to test Hypothesis I was found to be not significant ($F = 1.463$, $df = 12/60$, $p = .164$). Dayton (1970, p. 312), on the other hand, regarded the assumption of homogeneity of regression as "critical to the analysis of covariance since it is known that departures from this condition can seriously affect the actual risk of a Type I error". A type I error occurs when a true null hypothesis is rejected.

Table 27

Unadjusted Group Means and Standard Deviations for Pre- and Posttherapy Measures

		PREGWBS	POSTGWBS	PREPPCL	POSTPPCL	PREPPTH	POSTPPTH	PRECARS	POSTCARS	THERSAT	SESSIONS
T_0	$\bar{x}$	44.93	66.93	11.93	7.79	12.57	7.64	58.57	72.36	16.43	8.29
	sd	26.43	17.27	2.37	2.91	2.07	3.23	19.84	23.78	5.91	3.93
T_1	$\bar{x}$	47.64	64.36	11.14	8.14	10.64	8.14	72.64	79.79	19.79	6.50
	sd	16.22	17.61	2.07	2.71	1.39	2.45	16.09	19.45	4.48	4.59
T_2	$\bar{x}$	54.50	69.36	11.71	7.50	12.00	8.29	50.57	73.86	20.79	8.21
	sd	27.38	22.29	1.77	4.07	1.57	3.99	13.16	24.99	5.94	5.22

In this case the null hypothesis was not rejected and consideration did not have to be given to Dayton's warning.

Since the assumption of homogeneity of regression could not be met and the correlations between covariates and dependent variables were not consistently high (see Appendix I), use of covariates in the analysis was not entirely appropriate (Dayton, 1970; Kerlinger, 1973). Therefore, a second multivariate analysis was performed without using pretest scores as covariates. Since subjects were randomly assigned to groups, all possible independent variables were controlled for, theoretically at least, and group posttest scores could be compared using a multivariate procedure (Huck, Cormier, & Bounds, 1974; Kerlinger, 1973). It should be noted that the MANOVA computer program used did not allow the assumption of equal dispersion matrices (analogous to the assumption of homogeneous variances in the analysis of variance) to first be tested. While some researchers believe the MANOVA procedure to be relatively robust with respect to violations of the assumption (Huck, Cormier, & Bounds, 1974), Amick and Crittenden contended that any researcher who failed to test the assumption proceeded "at his own risk and may find that the F test for the differences between group centroids is inflated" (p. 227). In this instance the multivariate analysis of variance for the six continuous dependent variables was not significant ($F = .970$, $df = 12/68$, $p = .485$), even though the F value may have been inflated. Thus, the null hypothesis of no difference in mean scores among the treatment groups was accepted.

A visual inspection of the raw data in Table 27 and a graphical presentation of the pre- and posttherapy scores for GWBS, PPCL, PPTH and CARS in Figure 2 confirm that there was no consistent treatment effect.

Hypothesis II. The proportion of mutually terminated clients in each group will be the same.

Because it was a dichotomous variable, type of termination (i.e., mutual client and therapist decision versus unilateral client decision) was not included in the MANCOVA analysis. However, a visual inspection of the termination data (Table 28) indicates that there were no significant differences in the proportions of mutually terminated clients among the three groups. Thus, the null hypothesis was accepted.

Table 28

2×3 Contingency Table for Terminations by Group ($n = 42$)

	T_0	T_1	T_2
Mutual	10	14	13
Unilateral	4	0	1

A χ^2 analysis could not be performed since more than 20% of the cells had expected frequencies of less than 5 (Siegel, 1956, p. 110). It should be noted that 19 of the 42 In Study clients had not been terminated at the time of posttesting, three months after their intake sessions. All such clients were scored as mutual terminators since they were obviously engaged in therapy and motivated enough to return for continuing treatment.

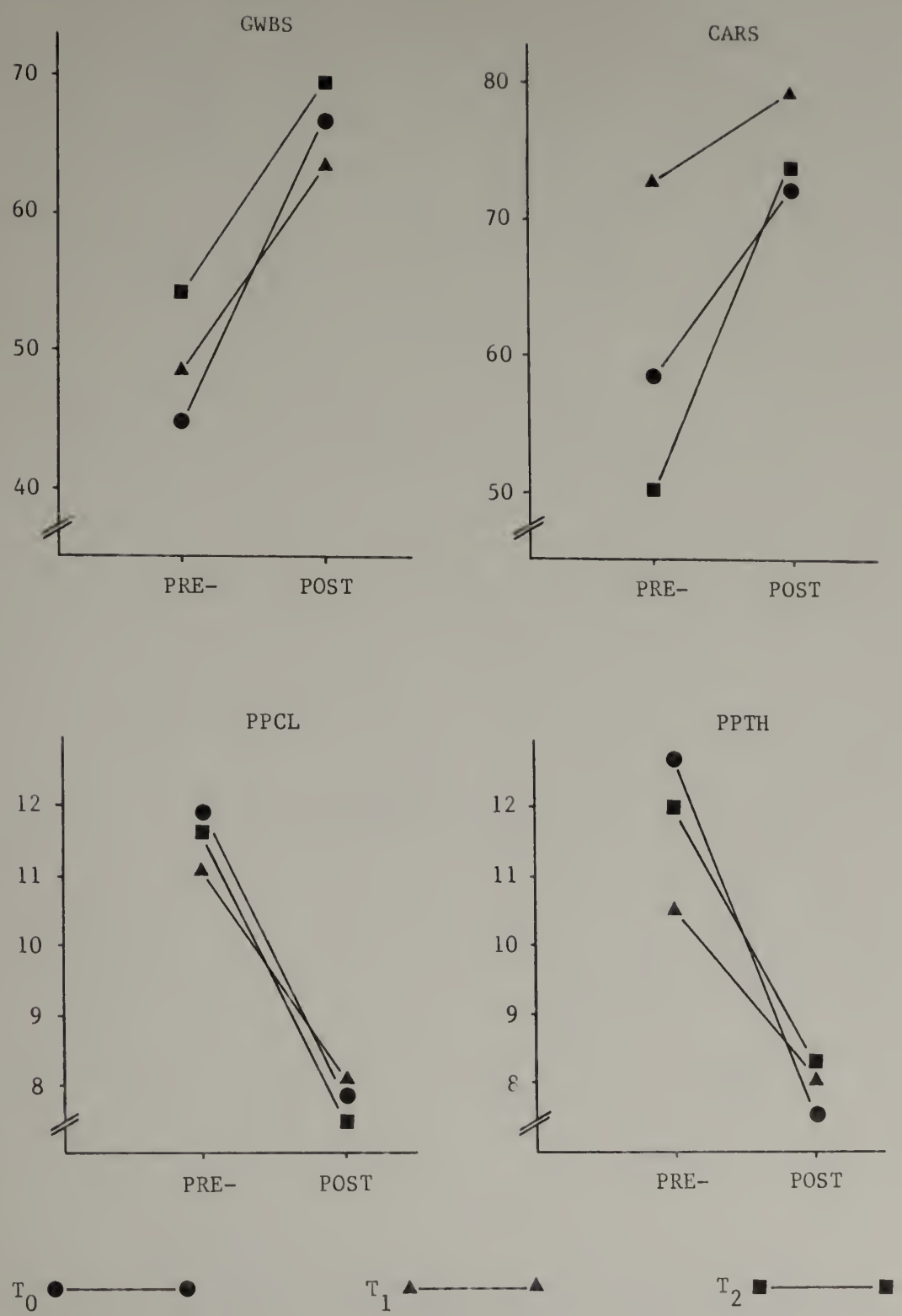

Figure 2: Mean Pre- and Posttherapy Scores for T_0, T_1, and T_2 Subjects

When type of termination for the 27 Drop-out clients (those for whom follow-up data was unobtainable) was included in the termination contingency table, there were still no significant differences in the proportions of mutual terminations across groups (see Table 29).

Table 29

2×3 Contingency Table for Terminations by Group ($n = 69$)

	T_0	T_1	T_2
Mutual	11	18	15
Unilateral	12	5	8

$\chi^2 = 4.65$, $df = 2$, $p < .10$, not significant

When the data for the two treatment groups (T_1 and T_2) were combined (see Table 30), there were again no significant differences in the proportions of mutually terminated clients in the two groups. However, as in Table 29, the data in Table 30 suggest that receiving information about the therapists in the Center can result in some reduction of unilateral terminations, a factor shown in a previous study to be related to favorable therapy outcome (Fiester, 1979). The same trend is evident in Table 31 where only the 42 In Study clients are considered.

Table 30

2×2 Contingency Table for Terminations by Group ($n = 69$)

	T_0	$T_1 + T_2$
Mutual	11	33
Unilateral	12	13

$\chi^2 = 2.831$, $df = 1$, $p < .10$, not significant

Table 31

2×2 Contingency Table for Terminations by Group ($n = 42$)

	T_0	$T_1 + T_2$
Mutual	10	27
Unilateral	4	1

$\chi^2 = 3.434$, $df = 1$, $p < .10$, not significant

Hypothesis III. There will be no difference in mean Reaction to Center (RECENTER) scores among the three groups.

A one-way analysis of variance was used to simultaneously compare the three group means presented in Table 32. The results of the ONEWAY analysis are presented in Table 33 and indicate that the mean differences among groups failed to reach significance. Thus, the null hypothesis was accepted.

Table 32

Group Means and Standard Deviations for RECENTER

	$\bar{x}$	sd
T_0	22.50	7.21
T_1	26.57	6.58
T_2	22.21	8.89

Table 33

Analysis of Variance of RECENTER Scores

Source	Sum of Squares	df	Mean Squares	F
Between groups	166.33	2	83.17	1.432*
Within group	2 265.29	39	58.08	
Total	2 431.62			

*$p = .251$, not significant

Since using group means can obscure group differences in patterns of responses to individual items, the item means for each group were ranked. Both the Drop-out and In Study clients in each group were included in the rankings. Thus, each group had an $n = 23$. Next, the degree of correlation among the three sets of rankings was calculated using the Kendall coefficient of concordance, W (Siegel, 1956). The significance of the Kendall W was tested using the method outlined in

Siegel, p. 235. Group item means and rankings are presented in Table 34. The coefficient of concordance ($\underline{W} = .922$) was found to be significant ($\chi^2 = 22.13$, $\underline{df} = 8$, $\underline{p} < .01$). Thus, not only were there no differences among mean RECENTER scores, but also there was a high degree of similarity among groups' patterns of responses to individual items.

Table 34

Group Item Means and Ranks for RECENTER

	T_0		T_1		T_2	
Item	mean	rank	mean	rank	mean	rank
1	1.70	2	2.22	4	1.61	2
2	1.91	3	2.09	3	1.74	3
3	2.74	5	3.00	7	3.00	6
4	3.44	9	3.52	9	3.17	8
5	3.04	7	2.96	6	3.04	7
6	3.39	8	3.44	8	3.39	9
7	1.65	1	2.04	2	1.48	1
8	2.78	6	2.83	5	2.52	5
9	2.22	4	1.96	1	2.22	4

In addition to the nine RECENTER items having seven point "strongly agree/strongly disagree" response scales, an open-ended tenth item asked clients to "Please list any other feelings or thoughts you have about coming to the Center". The verbatim responses of each group of clients are presented below.

T_0 Clients

1. I hope that my explinations will be coherent enough to receive the attention I believe is required to give me help.
2. Nervous, tense, anxious, scared
3. Its refreshing to feel understood. Plus I feel somewhat more confident. But only slightly.
4. Wanted come and talk with someone about getting some help with the problem I've now.
5. I feel better that I cam but I have a lot on my mind and I am happy that people want to help. All that I have to do is let them.
6. Since I have been a client here, I feel great relief from any problem I'm now experiencing.
7. Just getting my baby back.
8. None what so ever.
9. We want to get help at any price.
10. The only thing I want is to feel untired and useful to cesioty (everyone and everything!
11. I need help and this is the place to help me.
12. I am just afraid my feeling will get worse. And I'm afraid it will affect my future and my daughters.

T_1 Clients

1. I think I should come. I need help.
2. Gives me an outlet for my feelings. Helps me understand my self.
3. its the first time in a long time that I have had a problem of this nature and had someone actually pulling for me.
4. I hope they can help me as much as possible.
5. Hope that someone professionally can change things in our marriage.
6. I feel they can help me at the Center.
7. I have no other thought right now. You have covered most if not all of them. Thank you.
8. I feel more positive about your approach than other methods tried. Hopeful.
9. too soon to have any
10. From past experience I've learned that no one can help me until I decide to help myself. I know I do need it and that a sounding board is a good way to help myself. I'm very young and I'm very together as far as what's wrong/right and what I want/don't want. But some times things just build up and right now I'm confused and don't know which way to turn next. I hope that by coming here I'll put myself back on the right track.
11. Degree's mean nothing to me, it is how the counselor relates to me that matters.

12. I feel it's a beginning a new and better life for me! (Or should I say like I use to enjoy!)
13. I feel that the center could help in getting my self back together.

T_2 Clients

1. Do they really send out to employment?????
2. Its something that I feel I must do if I'm going to myself in a positive way.
3. I'm looking forward to conquer my frights and to feel like myself once again.
4. To get some help. To make your suggestion heard. To get protection.
5. I feel it will help me.
6. Well, if the price of gasoline wasn't so high maybe I can afford.
7. I am somewhat frightened as its difficult to trust.
8. I have confidence things will get better.
9. Some of the questions I can't answer, because I do not have the answers, as yet.
10. I think it will help me in the long run to cope with my problem. I might....

The responses could not be categorized in any meaningful way and there do not seem to be any obvious differences in response content or themes among the three groups. Clients in all three groups seemed generally positive, hopeful, or motivated with respect to receiving help. The number responding in each group was similar as well.

To summarize the results of hypothesis testing, all three of the formal null hypotheses were accepted. There was no significant treatment effect, there were no group differences in the proportions of mutual to unilateral terminations, and the groups did not differ in their initial reactions to the Center.

Reaction to Choosing

Reasons for Choice. The Reaction to Choosing Questionnaire (RECHOOSE) consisted of two parts and was administered to the 23 T_2, or choice-of-therapist, clients. Included in the 23 were two clients who declined to make a choice. Since responding to the questionnaire involved evaluating the reasons for choosing and the impact of choosing on self, these two clients were excluded from further analysis. Thus, only 21 clients were included in the analysis that follows.

The first part of the questionnaire asked clients to indicate how important various therapist qualities were in choosing their therapist. Scoring involved calculating group means for each item and then ranking the therapist qualities from most to least important. The results are presented in Table 35.

The first three items are "relationship" items while four out of the last five items are "physical appearance" items. Clearly, clients rated qualities that seemed indicative of a favorable relationship as important, and the physical appearance or similarity qualities as unimportant.

Part I item means for the 12 In Study clients and the 9 Drop-out clients were ranked. Results appear in Table 36. Next, the degree of correlation between the two sets of rankings was calculated using the Kendall rank correlation coefficient, r (Siegel, 1956, p. 213). The significance of the correlation coefficient was tested using the method described in Siegel, p. 220. The obtained correlation coefficient ($r = .798$) was highly significant ($p < .001$).

Table 35

Importance of Therapist Qualities to Clients Choosing a Therapist

Item	Mean Score (n = 21)	Rank	
Friendly	1.50	1	
Understanding	1.52	2	IMPORTANT
We will get along well together	1.86	3	
Able to help me figure out what I want to do	1.91	4	
Able to get things done for me	2.17	5	
Looks like the kind of person who will listen to me	2.43	6	
Will tell me what to do	2.55	7	
Looks strong enough to handle my problems	2.61	8	
Same age	3.13	9	
Same sex	3.47	10	
Reminds me of someone I know	3.57	11	
Attractive	3.70	12.5	UNIMPORTANT
Same Race	3.70	12.5	

Thus, both groups of clients exhibited highly similar patterns of responses to the 13 therapist qualities items.

Table 36

Group Item Means and Ranks on RECHOOSE, Part I

Item	In Study ($n = 12$) $\bar{x}$	rank	Drop-outs ($n = 9$) $\bar{x}$	rank
1	3.43	9.5	2.67	8
2	2.07	5	2.00	5
3	3.43	9.5	3.56	11.5
4	3.57	11	3.56	11.5
5	2.29	7	3.11	9
6	1.36	1	1.78	3
7	3.93	13	3.33	10
8	2.21	6	2.11	6
9	3.71	12	3.67	13
10	1.93	3.5	1.89	4
11	1.93	3.5	1.75	2
12	2.79	8	2.13	7
13	1.57	2	1.38	1

To see if the clients' ratings of the importance of therapist sex, age and race matched their actual choice of a therapist with respect to these variables, the Fisher exact probability test (Siegel, 1956) was used to test whether the indicated client groups differed in the proportions which paired themselves with therapists on the three variables. Contingency tables 37-39 show the observed frequencies for sex, age and race respectively. Note that the data for age and race were combined to yield two categories. There were no significant

proportional differences for sex and age, df = 1, p = .527 and .179, respectively. Clients did not prefer same sex or same age therapists, a finding that is in accordance with the low importance ranking of the "same sex" and "same age" items. The non-significant result for age is not surprising in view of the relatively narrow range of the therapists' ages. However, the result for race was significant (df = 1, p = .021). It was clear that Non-white clients preferred Non-white therapists. This seems to contradict the low importance ranking accorded the "same race" item.

Table 37

2×2 Contingency Table (Sex)

	Therapists: female	Therapists: male	
Clients: female	4	8	12
Clients: male	4	5	9
	8	13	21

df = 1, p = .527

Table 38

2×2 Contingency Table (Age)

	Therapists: < 30 years	Therapists: ≥ 30 years	
Clients: < 30 years	8	6	14
Clients: ≥ 30 years	2	5	7
	10	11	21

df = 1, *p* = .179

Table 39

2×2 Contingency Table (Race)

	Therapists: Non-white	Therapists: White	
Clients: Non-white	10	1	11
Clients: White	6	4	10
	16	5	21

df = 1, *p* = .021, significant beyond .05 level

Impact of Choice. The second part of the questionnaire assessed the impact choosing had on clients. Scores for all clients were obtained by summing their responses on the nine items. The group's average of 18.6

yielded an average of 2.07 per item, a clear indication that choosing was perceived as a positive act. The range of scores for all clients was 9 to 26 while the range of possible scores was 9 to 45. Thus, no one perceived choice as having negative impact on them. Table 40, which ranks average scores for all nine items, indicates that choosing seemed to enhance clients' images of themselves and made them willing and hopeful participants in their own therapy.

Table 40

Impact of Choosing a Therapist

Item	Mean Agreement Score ($n = 20$)*	Rank	
Choosing makes me feel:			
others respected my opinions	1.65	1	MORE AGREEMENT
responsible for myself	1.70	2	
**unimportant	1.90	3.5	
more willing to talk openly	1.90	3.5	
hopeful about solving my problems	2.05	5.5	
more in control of my life	2.05	5.5	
**Choosing is the clinic's job, not mine	2.30	7	
**Choosing confused me	2.35	8	
**Choosing made me worry about making a bad choice	2.85	9	LESS AGREEMENT

*n = 20 since there was missing data for one client

**Negatively worded items. Scored in reverse.

Mean impact-of-choice scores (Part II of the questionnaire) for the Drop-out clients and In Study clients were compared by means of a t test for independent samples. While the lower mean score for the In Study clients indicated that choosing had a more favorable impact on them (17.50 vs. 20.63), this difference was not significant ($t = 1.57$, $df = 18$, $p < .20$). Thus, the suggestion that the two groups were impacted differently by choosing could not be used to explain the failure of some clients to provide posttherapy data.

Clients' verbatim responses to two open-ended questions (Part I--List any other qualities that were important to you that are not included above; Part II--List any other ways choosing made you feel) appear below:

Part I:

1. like I was choosing from a group of professionals so I had nothing to worry about.
2. I really appreciated the choice, makes me feel more confident.
3. Important.
4. Willing to talk about anything I want to talk about.
5. Its important to lift weights.

Part II:

1. Coy and demure again.
2. Scary
3. I'm picking someone who I think would be able to help me.
4. By listening to person I chose counselor that I felt I could relate to easier and feel more comfortable with.

With one exception, the comments in Part I tended to reinforce the notion that choosing was important and probably reassuring to clients. While only four clients responded to the open question in Part II, two cited positive aspects of choosing. The remaining two indicated that the act of choosing may have had some negative associations for them.

Additional Analyses

Having determined that there were no group differences on outcome measures and no significant differences among the three groups' initial reactions to the Center, it was necessary to determine the extent of the Center's therapeutic effectiveness with clients. A situation in which all three groups of clients regressed or made no progress during therapy would obviously be very different from the situation in which all groups gained significantly from therapy.

One way of answering this question was to simply compare the number of clients who registered gains on the four outcome measures (GWBS, PPCL, PPTH, CARS) with those who stayed the same or declined. The results are shown in Table 41.

Table 41

Posttherapy Gains or Losses on Four Outcome Measures

Outcome Measure		Group				
		T_0	T_1	T_2	Total	% of Total Clients
GWBS:	gain	11	12	10	33	78.5
	loss	2	2	3	7	
	same	1	0	1	2	
PPCL:	gain	12	11	10	35	83
	loss	2	2	2	6	
	same	0	1	0	1	
PPTH:	gain	12	10	10	32	76
	loss	1	0	3	4	
	same	1	4	1	6	
CARS:	gain	10	11	12	33	78.5
	loss	3	3	2	8	
	same	1	0	0	1	

Inspection of the data reveals that there are no differences among the groups in terms of the ratio of clients who gained to clients who stayed the same or regressed. Similarly, the total number of clients who gained on each of the measures was quite consistent and averaged 79% over all four measures.

Table 42 sets out the number of measures on which clients in each treatment group registered gains.

Table 42

Number of Measures on which Clients in Each Group Gained

	Group				
	T_0	T_1	T_2	Total	
Gains on:					
4 measures	6	7	10	23	> 74%
3 measures	5	3	0	8	
2 measures	2	3	1	6	
1 measure	1	1	2	4	> 12%
0 measure	0	0	1	1	

It can be seen that more of the choice-of-therapist clients registered gains on all four outcome measures. Also, 74% of 42 clients made gains on at least three of the four outcome measures and only 12% of the clients gained on less than two of the measures.

In summary, whatever method of counting was used, 3 out of 4 clients registered gains in therapy and this number was consistent across treatment groups.

Another means of determining the Center's therapeutic effectiveness was to test whether the gains from pretest to posttest were significant for all 42 clients and each of the three treatment groups. The method of data analysis for a two-factor experiment with repeated measures on one factor was used to analyze the total subject ($n = 42$) and separate treatment group ($n = 14$) gains on each of four outcome measures: GWBS, PPCL, PPTH, CARS (Winer, 1971). In this case the summary analysis of variance took the following form:

Source of variation	df
Between Subjects	41
Treatment (3 levels)	2
Error-between	39
Within Subjects	42
Occasion (pre and post)	1
Interaction	2
Error-within	39

The results of the analyses for each of the four outcome measures with $\alpha = .05$ are presented in Tables 43 - 46. When k hypotheses are tested, each at level α, the probability of rejecting at least one of the k hypotheses is $1 - (1 - \alpha)^k$ (Hays, 1973). Since this is roughly equivalent to $k\alpha$, partial control for this experiment-wise error can be gained by dividing α by the number of hypotheses to be tested. Thus, when conducting the four analyses of variance with $\alpha = .05$, each test would have to be significant at the $.05 \div 4$, or .013, level of significance. It can be seen that for each variable the main effect of Occasion, for which there was

only two levels, was significant: that is, the therapeutic gains from pre- to posttest made when all 42 clients were considered together were highly significant. The main effect of Treatment and the interaction of Treatment and Occasion were not significant for any of the four variables.

Table 43

Analysis of Variance for GWBS

Source of Variation	df	MS	F
Between Subjects	41		
Treatment (T)	2	332.1	.490
Error-between	39	678.4	
Within Subjects	42		
Occasion (O)	1	6696.4	25.73*
TO	2	96.1	.370
Error-within	39	260.3	

*$p < .001$

Table 44

Analysis of Variance for PPCL

Source of Variation	df	MS	F
Between Subjects	41		
T	2	.51	.313
Error-between	39	1.6	
Within Subjects	42		
O	1	301.3	22.13*
TO	2	3.3	.243
Error-within	39	13.6	

*$p < .001$

Table 45

Analysis of Variance for PPTH

Source of Variation	df	MS	F
Between Subjects	41		
T	2	14.0	2.06
Error-between	39	6.8	
Within Subjects	42		
O	1	301.5	38.16*
TO	2	3.2	.405
Error-within	39	7.9	

*$p < .001$

Table 46

Analysis of Variance for CARS

Source of Variation	df	MS	F
Between Subjects	41		
T	2	1503.3	2.29
Error-between	39	655.2	
Within Subjects	42		
O	1	4513.1	31.56*
TO	2	485.6	3.40
Error-within	39	143.0	

*$p < .001$

Since there were no treatment or interaction effects and only two levels of occasion, it could therefore be assumed that each group contributed equally to the highly significant increase in posttest scores on all four outcome variables. In summary, all three groups made gains on the four pre- and posttest measures of outcome.

A further indication of the Center's effectiveness was found by comparing pre- and posttherapy GWBS scores with Dupuy's (1978) categorical descriptions of GWBS scores (see p. 98). Before therapy both group and overall mean GWBS scores ($T_0 = 44.93$, $T_1 = 47.64$, $T_2 = 54.50$; overall = 49.02) could be categorized as indicative of "severe distress" (0-60 = severe distress, 13.5% of the U.S. adult population). After therapy, however, both group and overall mean GWBS scores could be categorized as indicative of "moderate distress" ($T_0 = 66.93$, $T_1 = 64.36$, $T_2 = 69.36$; overall = 66.88; 61-72 = moderate distress, 15.5% of the U.S. adult population).

Finally, the average number of sessions could be taken as an additional indication of the Center's therapeutic effectiveness. The average number of sessions per client (7.67) was higher than the average for the 18 months prior to the present study (6.85). When it is considered that 19 of the 42 clients had not been terminated at the time of posttesting and were thus recorded as mutual terminators, mean sessions per client over the whole course of therapy would be even higher. Since Orlinsky and Howard's (1978) review of 33 studies addressing the question of length of treatment determined that there was a positive association between amount of treatment and therapeutic

benefit, especially when number of sessions rather than total duration was used, it seemed likely that the Center had increased its effectiveness over its former level. While this information is limited in that it does not specify or estimate the Center's current level of effectiveness, it supports other evidence of effectiveness already presented in this section.

CHAPTER VI

SUMMARY, DISCUSSION AND IMPLICATIONS

Summary of Results

Three formal hypotheses were tested to examine differences among the three treatment groups. The first had six continuous measures of therapeutic gain as dependent variables while the second had the dichotomous variable of type of termination as the dependent variable. The third hypothesis used clients' reactions to their initial experience of the Center as a continuous dependent variable. An initial one-way multivariate analysis of covariance with six criteria and four covariates was used to test the first hypothesis; tabular presentation and χ^2 analysis was used to test the second; and a one-way analysis of variance was used to test the third.

The null hypothesis for Hypothesis I was accepted. There were no significant differences in therapy outcome among the three groups: controls (T_0), information but no choice (T_1), and information plus choice (T_2).

The null hypothesis for Hypothesis II was also accepted. There were no differences among the three groups with respect to type of therapy termination.

For Hypothesis III the null hypothesis of no difference in average Reaction to Center scores among groups was accepted. Furthermore, groups' patterns of responses to the individual items were significantly

correlated. Finally, the groups' responses to an open-ended item failed to reveal group differences in initial experience at the Center, attitude toward the Center, or expectations regarding therapy.

Reasons for clients' choices and the impact choosing had on them were assessed. Choice clients rated therapist "relationship" qualities (e.g., friendly, understanding, will get along well together) as most important and "physical appearance" items (e.g., same age, same sex, attractive, same race) as least important when making their choice. However, in contrast to the low importance accorded "same race" as a reason for choosing, Non-white clients chose same race therapists significantly more frequently than did White clients. Clients' mean response to Impact of Choosing items was 2.07 on a five point "strongly agree/strongly disagree" scale, suggesting that, overall, choosing was perceived as a positive act.

Finally, additional analyses were carried out to determine whether the three groups of clients improved, regressed or stayed the same as the result of therapy. This was done by counting the number of clients who gained on each outcome measure, by counting the number of measures on which individual clients registered gains, by using an analysis of variance with repeated measures on one factor to assess the total clients' and each group of clients' gains on each of the four pre- and posttest measures (GWBS, PPCL, PPTH, CARS), and by comparing pre- and posttherapy GWBS scores with Dupuy's (1978) categorical descriptions of mental distress among U.S. adults. Findings indicated that (a) the number of clients who gained on each measure was the same for all three groups and averaged 79% over all four measures, (b) three out of four

clients registered gains on at least three of the four measures and this number was consistent across all three groups, (c) all three groups tended to make significant gains on each of the four pre- and post-therapy measures, and (d) all three groups' posttherapy GWBS scores indicated that their levels of mental distress had improved from "severe" to "moderate".

In summary, there was no significant treatment effect, even though choice clients' responses to questions designed to assess the impact choosing had on them suggested that choice made them willing and hopeful participants in their own therapy. More importantly, therapy was equally effective for clients in all three groups. It was clear that choice subjects gained at least as much in therapy as the other two groups. Thus, since choice by itself did not seem to affect therapy outcome, an argument in favor of the implementation of client choice of therapist procedures must be based on other reasons.

Discussion

Hypothesis I. There will be no differences in mean scores among the three treatment groups on the six, continuous, outcome measures (GWBS, PPCL, PPTH, CARS, THERSAT, SESSIONS).

There are a number of possible explanations for the fact that the null hypothesis was not rejected.

1. The actual treatment procedure of choosing was brief and occurred only once--during the intake session. Exposure to a presentation that was less than 15 minutes in length may have been too short to expect there to be measurable effects three months later.

It seems more plausible that while information about therapists and the opportunity to choose a therapist would have an initial positive impact on clients' attitudes to therapy (i.e., hopefulness regarding outcome, willingness to engage in and participate in therapy), this impact might be dissipated, displaced or overtaken by other subsequent influences. Partial support for this notion of positive initial impact can be found in the Reaction to Choosing, Part II, data where the mean item response was a favorable 2.07, i.e., "agree" on a five point "strongly agree/ strongly disagree" scale (see Table 40).

Evidence reviewed in Chapter II concerning the impact of choosing on attitude to a task or process, but not necessarily performance, was mixed. In an educational study Myrow (1973) found that while there was no difference between choice and no-choice of study topic groups in terms of retention of study material, choice students expressed a greater liking for the study materials and spent more time studying than no-choice students. A counseling analogue study by Ersner-Hershfield et al. (1979) found that while there were no differences between choice and no-choice subjects on counseling outcome, 71% of the choice clients versus only 45% of the controls showed for their first therapy interview. A counseling analogue study reporting contrary results (Ferreira, 1975) indicated that neither client choice nor expectancy of being paired with a preferred counselor affected client readiness for counseling. Thus, the present study supports the notion that while choice may not affect actual performance or outcome, it can have positive impact on clients' initial attitudes toward therapy.

2. Another source of difficulty was the fact that two different

types of matching were being compared. While this comparison was realistic given the procedure in most mental health clinics, it may well have been the case that the Clinical Director's personal method of assigning client to therapist was already an effective matching procedure. The clinic's generally high rate of success (e.g., approximately 75% of those who continued in therapy registered significant gains) supports this possibility. If this was so, client choice of therapist as a method of matching demonstrated its value by equalling the Clinical Director's rate of success.

3. As stated in the experimental design section of Chapter IV, the presentation of the sound/slide tape with or without choice preceded the T_1 and T_2 clients' completion of the pretest measures. Numerous writers (Dayton, 1970; Hays, 1973; Winer, 1973) have warned of the possible influence of treatment on covariates when this sequencing occurs and suggested that this may effectively remove treatment effects from criterion scores. To check this possibility a multivariate analysis of variance was performed on pretherapy scores. A .05 level of significance was used. The resulting F was significant ($F = 2.512$, $df = 10/64$, $p < .013$). Follow-up univariate F tests indicated that the two pretherapy measures completed by therapists contributed to the significant F. The results of the univariate tests appear in Table 47.

From the data presented in Table 27 it can be seen that the group PREGWBS scores, although not significantly different, are in the direction we would expect treatment influence to operate. The GWBS and the RECENTER instruments were the only two measures completed immediately following administration of the treatment. Thus, for the GWBS it appears

Table 47

Follow-up Univariate Tests on Pretherapy Variables

Variable	MS	Univariate F	p
PREGWBS	340.67	.65	.527
PREPPCL	2.31	.61	.549
PREPPTH	13.74	4.85	.014*
PRECARS	1 748.02	6.07	.005*

*significant beyond .05 level

possible that the order of treatment and pretesting may have removed some of the treatment effect from the criterion scores.

The situation is not as clear with the PPCL, PPTH, and CARS measures. All three of these instruments were completed at the time of the clients' first therapy session, usually a week after completion of the GWBS. It should be noted that only the PPCL was completed by clients. While the combined mean scores for T_1 and T_2 on PPCL, PPTH and CARS were in the "influenced" direction, the T_1 group had higher adjustment/health scores than T_2 on all three measures. In fact, it is clear that the T_1 scores on PPTH and CARS account for the significant multivariate F on pretherapy scores. Since subjects were randomly assigned to groups, we must assume that some factor like the influence of treatment on pretherapy scores was operating, though why it operated most strongly on the therapists' ratings of the T_1 group cannot be explained. However, the real possibility that treatment influenced pretherapy scores and effectively removed some treatment effect from criterion scores remains.

4. Since the assumption of homogeneity of regression in the multivariate analysis of covariance was rejected, the simple question of overall differences among group posttherapy means after adjustments were made for pretherapy differences was no longer appropriate. It was more likely that the groups differed in various ways on adjusted posttherapy scores for various pretherapy scores (Tatsuoka, 1971). Thus, treatment effects alone would not adequately account for any differences found.

5. Number of therapy sessions (SESSIONS) did not differentiate groups. One reason for this was the fact that so many clients (37 of 42, or 88%) were mutual terminators and therefore had continued in therapy rather than discontinuing after only a few sessions. This fact, plus the Center's high rate of success (approximately 75% of clients in all three groups recorded gains in therapy), combined to render SESSIONS ineffective in differentiating the three groups.

6. While group differences in Therapists' Satisfaction with Therapy (THERSAT) scores did not reach significance, scores for T_1 and T_2 clients were considerably higher than they were for T_0 clients. This difference was obscured in the multivariate analysis by the inconsistent differences among groups on the other variables.

One possible criticism of the research design involved the fact that therapists might find out which clients belonged to which group. While this information was purposely not conveyed to therapists, and clients' records were coded to prevent their group membership being widely known, it was possible that therapists eventually found out which clients had chosen them. One obvious source of such information

was the clients themselves. However, rather than being a design flaw which confounded results, therapist knowledge of which clients had chosen them could actually be considered part of the treatment effect. It has been suggested previously that therapists who are chosen might be motivated to work more diligently and effectively with choice clients (Lazare et al., 1972; Palmer, 1973). In any agency employing a client choice-of-therapist procedure, therapists would automatically know they had been chosen and any positive therapeutic benefits associated with this knowledge would be accepted as an additional favorable consequence of the choice procedure. Thus, in the present study where an attempt was made to test the effect of client choice under real rather than analogue conditions of therapy, there was no need to ensure complete control of therapists' knowledge of client group membership. Results, however, revealed that there were no group differences on any of the outcome measures, and even though therapists tended to express greater satisfaction with T_1 and T_2 clients, this difference was not significant.

The findings of the present study contradict the results of the only other study reviewed in Chapter II that was conducted under authentic conditions of therapy. Devine and Fernald (1973) found that clients matched with their preferred therapy/therapist showed greater improvement after a two session treatment program than clients who were randomly assigned or assigned to a non-preferred therapy/therapist. Although two other articles described situations in which real clients chose either therapists or therapies (Ewing, 1977; Nuttey, 1969), neither reported data regarding success or effectiveness. Of the five analogue studies reviewed that used subject choice of therapist or therapy as a

treatment effect (Brown, 1977; Ersner-Hershfield et al., 1979; Ferreira, 1975; Gordon, 1976; Moore, 1976), only Gordon reported positive results, i.e., choice-of-treatment subjects valued treatment more and reported it to be more effective. The other four found no measurable outcome differences between choice and control subjects. It should be emphasized that all of the analogue studies assessed outcome (usually in terms of client and therapist satisfaction or relationship scores) after only one interview. Thus, the results of the present study are supported by the findings of four analogue studies and contradicted by two studies, only one of which was an authentic therapy situation. The question of the effect of client choice on therapy outcome therefore remains unanswered. A few studies cannot establish fact. A more realistic goal is replication of findings, "with the replications being obtained by varied investigators working in varied settings, and preferably by varied methods of observation and data collection" (Fiske, 1977, p. 24).

Hypothesis II. The proportion of mutually terminated clients in each group will be the same.

One possible reason why this hypothesis was not rejected had to do with the racial composition of the Center's therapy staff (see Table 25). Of the eight therapists, two were White, two were Hispanic, and four were Black. It is possible that the 45% of the clients who were Non-white may have felt favorably disposed toward the Center, felt more able to identify with the Center's racially mixed staff, and, generally, felt less alienated in the clinic setting than has been reported

elsewhere (Sattler, 1977). The racial composition of the Center's staff is clearly atypical of the average mental health clinic (43% Black, 21% Hispanic and 36% White versus the national average of 14%, 5% and 79%, respectively). Thus, more clients may have entered and continued therapy in a setting and with staff they felt comfortable with, accepting of and accepted by. If these positive feelings persisted during therapy, they might have nullified any group differences in type of termination due to treatment effect.

Further support for this possibility was the fact that the average Reaction to Center item response on the seven point "strongly agree/ strongly disagree" scale was 2.64 (agree/agree somewhat) indicating a favorable initial response to the Center. There were no group differences in average scores or pattern of scores on individual items. The three items with the most favorable reaction scores supported the notion that clients felt accepted and were willing to participate in therapy: "I feel willing to talk about my problems with a counselor"; "I feel the Center respects me as a person"; "I feel the Center will take a real personal interest in me". Thus, clients in all three groups were equally positive about their therapy and had equally high rates of mutual terminations, a combination supported by Garfield's summary of studies on early termination (1971, p. 289): "It would appear that the client's expectancies concerning psychotherapy are of some importance for both therapy continuation and outcome."

Another reason Hypothesis II was not rejected may have been the overall high success rate of therapy. Results reported in Chapter V indicated that approximately 75% of clients in all three groups improved

during therapy and that the degree of mental distress as measured by the GWBS lessened for all three groups. It was possible that group self-terminations, reported previously to be correlated with lack of improvement in therapy (Fiester, 1979), were influenced more strongly by therapist effectiveness than by the treatment variable. Further evidence for this possibility is suggested by the increase in the percentage of mutual terminations from 35% in the 18 months prior to the present study to 64% during the present study. In the five months prior to the commencement of this study the Center doubled its staff, moved into improved accommodation and implemented more systematic staff training, all factors that could have operated to improve therapeutic services and keep clients in therapy, thereby reducing the number of self-terminations.

In spite of these possibilities the data in Tables 29 - 31 suggest that receiving the prior information, with or without choice, did reduce the rate of self-terminations, though not significantly so. It seems plausible that the effect due to treatment was mitigated by the factors discussed above.

Hypothesis III. There will be no difference in mean Reaction to Center (RECENTER) scores among the three treatment groups.

This hypothesis was not rejected. Not only were group mean scores similar, but also group item rankings based on mean item scores were the same. Thus, all three groups expressed equally favorable initial reactions to the Center.

The RECENTER questionnaire was an indirect measure of the effect of

the sound/slide presentation with or without choice of therapist. Since it was necessary to use a measure that would enable a simultaneous comparison of all three groups, a questionnaire assessing general reaction to initial experience at the Center was used in preference to a more specific measure aimed at assessing the effects of the sound/slide presentation. It was assumed that the effects of the presentation and choice of therapist would be reflected in the RECENTER questionnaire. The fact that this did not occur could indicate either that the RECENTER questionnaire did not measure what it was intended to measure (a problem of validity) or that effects due to treatment were mitigated by the Center's consistently welcoming, sensitive and supportive treatment of all new clients. Unfortunately, client responses to the RECENTER open-ended question ("Please list any other feelings or thoughts you have about coming to the Center") did not help to resolve the question. Responses were similar in both content and number per group ($T_0 = 12$ comments, $T_1 = 13$, $T_2 = 10$).

Reaction to Choosing

Clients' reasons for choosing different therapists were similar, indicating not only that "actual clients have implicit and explicit ideas concerning the characteristics they would like manifested in their counselors" (Rosen, 1967, p. 787), but also that different clients perceive different therapists as manifesting the same characteristics. However, when actual pairings were examined, Non-white clients selected Non-white therapists more frequently than could be expected by chance. Actual behavior seemed to contradict the low ranking accorded "same race"

as a reason for choice. White clients, on the other hand, had no consistent preference regarding therapist race. This finding is in accord with Sattler's (1977) suggestion that self-reported preferences may not necessarily reflect behavior in actual choice situations.

To investigate further the finding that clients will choose different clients for the same reasons, the sound/slide tape used in this study was presented to a non-client New Zealand population ($n = 55$). Subjects were asked to indicate the therapist they would prefer to work with and then to answer Part I of the RECENTER questionnaire (show how important or unimportant certain counselor qualities were in choosing a preferred therapist). A comparison of the therapist rankings for the present study clients and the New Zealand subjects is shown in Table 48. Table 49 presents RECHOOSE, Part I item means and rankings for each group.

Table 48

New Zealand and USA Rankings of Preferred Therapist

	USA ($n = 21$)		NZ ($n = 55$)	
Therapist	Frequency	Rank	Frequency	Rank
A	7	1	8	4.5
B	1	6	0	8
C	5	2	10	2.5
D	2	4.5	4	6
E	4	3	14	1
F	2	4.5	1	7
G	0	7.5	10	2.5
H	0	7.5	8	4.5

Kendall rank correlation coefficient (r) = .231, $p < .274$

Table 49

Group Item Means and Ranks on RECHOOSE, Part I

Item	USA (n = 21)		NZ (n = 55)	
	Mean	Rank	Mean	Rank
1	3.13	9	3.72	10
2	2.43	6	1.49	2
3	3.47	10	3.56	8
4	3.57	11	4.47	13
5	2.61	8	2.11	6
6	1.52	2	1.32	1
7	3.70	12.5	3.58	9
8	2.17	5	2.66	7
9	3.70	12.5	4.27	12
10	1.91	4	1.53	3
11	1.86	3	1.73	5
12	2.55	7	3.84	11
13	1.50	1	1.66	4

$r = .607$, $p < .002$

Use of a Kendall rank correlation coefficient (r) indicated that while the rankings of preferred therapists for the two groups (based on frequency of being chosen) were not significantly related ($r = .231$, $p < .274$), the rankings of the therapist qualities in terms of their importance to clients in choosing a therapist were highly related ($r = .607$, $p < .002$). These findings further reinforce the idea that people may choose different therapists for similar reasons, thus suggesting that individual clients are best suited to effect their preferred match. Certainly the idea of using easily elicited client preferences as a basis of matching would be a viable alternative to

present matching methods, e.g., pairings based on therapist or agency needs and preferences, or their perceptions of what would be best for clients.

From the USA data in Table 48 it appears possible that an order effect may have been operating with the sound/slide presentation. It was possible that fatigue, boredom or some other factor caused clients to choose lower order therapists less frequently than they did the first five therapists. Order of presentation could have been varied during the experiment to control for this possibility. However, the New Zealand data tend to disconfirm the possibility of an order effect, though it must be stressed that the New Zealand subjects were not real clients seeking therapy, but, rather, people participating in a hypothetical exercise.

It seems clear from clients' responses to Part II of the RECHOOSE questionnaire, which assessed the impact choosing had on clients, that choosing resulted in clients feeling more positive about themselves, more willing to engage in therapy, and more hopeful about its outcome. While this impact may have been temporary and was therefore not reflected in the T_2 group's outcome scores, it was also possible that the act of choosing might have helped to equalize the inherent therapist-client power imbalance repeatedly referred to in the literature (Darley, 1974; Hare-Mustin et al., 1979; Morrison, 1978; Rice & Rice, 1973; Ryan, 1871). In fact, results indicated that choice clients reported feeling respected, responsible, important and in control of self.

Interestingly, intake counselors reported that some T_1 clients

expressed a preference for a therapist after the sound/slide presentation. A few were disappointed that they could not choose. For these clients choice would presumably have been a meaningful and positive act.

Client responses to the RECHOOSE open-ended questions tended to reinforce the notion that choosing was important and probably reassuring to clients.

Additional Analyses. When it was evident that none of the null hypotheses had been rejected, it became important to determine how effective the therapy received by the three groups had been. Three types of comparisons were used to answer this question: first, a simple comparison of the number of clients in each group who registered gains on each of the four pre- and posttest measures (see Table 41); second, a comparison of the number of measures on which clients in each group gained (see Table 42); third, a repeated measures analysis of variance to test whether the gains from pre- to posttest were significant for all 42 clients and each of the three treatment groups (see Tables 43 - 46). The results of these comparisons indicated that at least 75% of the total clients improved as a result of therapy. Furthermore, whichever method was used to compare therapeutic gains, all three groups made similar gains on all four outcome measures. In addition, all three groups' posttherapy GWBS scores indicated that their levels of mental distress had improved from "severe" to "moderate". Therefore, while it was shown that experimental treatment did not differentiate groups of clients on therapy outcome, it was demonstrated that therapy was equally

effective across all three groups of clients. In other words, while choosing a therapist did not result in enhanced outcome relative to the other two groups, neither did it inhibit favorable outcome.

Summary of Discussion

A summary of findings and interpretations is presented below.

1. There are a number of plausible reasons why there were no outcome differences among the three groups:
   a. The treatment procedure may have been too brief to expect measurable effects to persist for three months.
   b. Choice-of-therapist was compared with the Clinical Director's personal method of client assignment, a method that may have already have been operating successfully to enhance outcome.
   c. There was some evidence that the experimental treatment, which preceded pretesting, affected pretest scores so that the analysis of covariance effectively removed some effect due to treatment from posttest scores.
   d. Rejection of the assumption of homogeneity of within-cell regression in the multivariate analysis of covariance suggested that testing for gross treatment differences among groups might have been inappropriate. A more useful, although more complex question, would have been to ask "Which pretest scores resulted in which posttest scores for which groups?"
2. Number of therapy sessions was ineffectual in differentiating groups. This was probably due both to the high ratio of mutual to self-terminations in all groups and the Center's overall

therapeutic effectiveness. Both factors indicated that clients were encouraged to continue in treatment. Therefore, number of sessions would tend to be similar for all three groups.

3. Therapists' satisfaction with groups T_1 and T_2 was greater than it was with the control clients, though not significantly so.
4. While not significant, there was a suggestion that receiving the therapist presentation reduced the number of self-terminations in groups T_1 and T_2. It was thought that this treatment effect was mitigated by the Center staff's multi-racial composition and the overall effectiveness of the Center's intake and therapy programs.
5. All three groups had equally favorable initial reactions to the Center as measured by the RECENTER questionnaire. Patterns of responses to individual items were similar as well.
6. Clients chose different therapists for the same reasons. Therapist qualities rated important were "relationship" qualities such as friendly, understanding, will get along well together, while qualities rated unimportant were "physical similarity/ appearance" factors such as same age, same sex, same race, attractive. Interestingly, a New Zealand sample of subjects not seeking therapy or personal support of any kind chose among the same therapists with different frequencies, but for the same reasons.
7. Non-white clients chose Non-white therapists, a fact that contradicted the clients' low rating of "same race" as a desired therapist quality.

8. Choosing appeared to leave clients feeling more positive about themselves, more willing to engage in therapy, and more hopeful about its outcome.
9. Each of the three methods used to assess gains in therapy indicated that at least 75% of all clients made substantial improvement and that all three groups made similar gains on all four pre- and posttherapy measures.
10. While choice-of-therapist did not result in enhanced outcome relative to the other two groups, neither did it inhibit favorable outcome.

Implications for Therapy

Literature on the concepts of client rights and consumerism-in-counseling reviewed in Chapters I and II lent considerable ethical and legal support to the notion of clients choosing their own therapists (see, for example, Margolis et al., 1977; Morrison, 1978; Personnel and Guidance Journal, December, 1977). Quite apart from the question of enhancing therapy outcome, it has been suggested that client choice of therapist is the right of every client, a means of redressing the inherently unequal client/therapist relationship, a way of demystifying the process of therapy, and a means of increasing clients' participation in the process of their own therapy. While efforts have been made to make counselors aware of and accepting of the rights of clients (Sue, 1977; Penn, 1977; Winborn, 1977), only a few writers have explicitly acknowledged that choice of a therapist or therapy is every client's right (Coyne & Widiger, 1978; Weinrach & Morgan, 1975).

Several examples of printed consumer's guides to mental health and social welfare services have been published to give potential consumers accurate, prior information about available treatment options and services (e.g., A Consumer's Guide to Mental Health Services, 1975; Adams & Orgel, 1975; Cohrssen & Kopolow, 1979; Marks, 1976; Peters, Lichtman, & Windle, 1979; Ruitenbeek, 1976). The intention of these guides was to reduce the feelings of fear, hesitation, and powerlessness with which many clients approached helping agencies.

Legal support for the notion of client rights and participation in program governance and evaluation derives from the Community Mental Health Centers Amendments of 1975. The intention of these Amendments was to foster improved citizen mental health "by encouraging community and client self-reliance and by helping to improve the responsiveness of community mental health centers' services to catchment area needs" (Peters, Lichtman, & Windle, 1979, p. iii). Active commitment to client rights and participation in program development was therefore mandated. More recently, The Report to the President from the President's Commission on Mental Health (vol. I, 1977) reviewed the nation's mental health needs and made specific recommendations regarding the protection of clients' rights. Specifically, the Commission recommended that each state adopt a "Bill of Rights" for all mentally disabled persons. Recommendations for a model were provided (see p. 72). The list of patients' rights in Sadoff and Kopolow (1977) exemplifies the aims of patients' rights advocates (pp. 38-39):

1. To be treated with dignity and respect by service providers, and to have one's humanity recognized throughout the course

of treatment.

2. Freedom from unnecessary hospitalization.
3. Freedom from unnecessary treatment.
4. The right to information about treatment - including treatment philosophy, style, duration and likely outcome.
5. The privilege of confidentiality.
6. The right to effective treatment (deals with the quality of treatment received).
7. The right to mental health services when and where they are needed.
8. The guaranteed opportunity to participate in treatment decisions affecting him/her.
9. The right to redress for grievances.
10. The right to have a patient advocate who is accountable only to the patient.

Rights 4 and 8 are directly relevant to the notion of client choice of therapist researched in this study. Client choice of therapist is a treatment decision that can only be made with prior information about available alternatives. The ideas of client rights, consumerism-in-counseling and patient participation in the organization and delivery of mental health services have been supported by professional help-givers, published as "how to" guides for various consumer groups, mandated by federal law, and advocated by a President's commission. Moreover, citizen participation in all phases of service planning, delivery and evaluation is likely to remain a part of future mental health programs since "public funding of health and mental health services will carry

with it the stipulation that consumers be involved from the very beginning" (Hunt, 1973, p. 4). When the weight of these favorable ethical, legal and social considerations are combined with the findings of the present study, which demonstrated that choice-of-therapist clients fared at least as well in therapy as other clients, it seems clear that "each client or patient must have the maximum possible opportunity to choose the unique combination of services and objectives appropriate to his or her needs" (The President's Commission on Mental Health, 1978, p. 42).

Choice, of course, means little unless accurate prior information about available alternatives is readily accessible to all clients. The consumer's dilemma has been recognized in the field delimited by the term "t-groups", where group leaders "have clearly failed to differentiate our offerings for the clients we serve....the real task will be to provide reasonable and recognizable distinctions that clients can use" (Lieberman, 1975, p. 246). This same dilemma exists in the wider field of mental health services. One of the purposes of the present study was to develop a practical, simple procedure for conveying such information to clients.

Various means have been employed in other studies to provide clients with prior information about therapists and therapies:

1. information transmitted either verbally by the researcher or in written form (Ferreira, 1975; Greenberg, 1969; Greenberg, Goldstein, & Perry, 1970).
2. audio-taped samples of therapy style (Cheney, 1975; Greenberg, Goldstein, & Gavle, 1971).

3. pictures of therapists (Boulware & Holmes, 1970).
4. client observations of and/or sampling of available therapies (Brown, 1977; Ewing, 1977).
5. video-taped samples of therapies (Devine & Fernald, 1973; Moore, 1976; Stranges & Riccio, 1970).

In the present study a color slide plus audio-tape presentation was used because it seemed likely that such a combined visual and auditory format would increase information available to clients. The presentation was brief (less than 14 minutes in length), technically simple (the presentation ran automatically once the audio cassette was started), inexpensive (cost of slides, tape recorder and projector would be within the means of every mental health clinic), and provided useful and accurate information that enabled "informed choice", even by marginally literate clients. A similar type of presentation could be easily developed for use in other treatment settings.

On the basis of this research it seems reasonable to recommend that clients be given detailed information about treatment, including data about therapists, treatment philosophies, styles, durations, and likely outcomes. There exists, after all, strong ethical and legal support for the notions of clients' rights and clients' participating in all aspects of their own therapy. If implemented, this single recommendation alone would begin to redress the inherent power imbalance between professional mental health workers and their clients.

Implications for Further Research

The effect of client choice of therapist on therapy remains an important question. While the review of literature on client-therapist matching in Chapter II indicated consistent support for the notion that certain client-therapist pairings enhance the therapeutic process, no single method of matching has yet been demonstrated to be both effective and practical enough to be used extensively. There were, however, suggestions that client selection of therapist as an alternative method of matching could have positive effects on both the process and outcome of therapy. It was clear that choice of therapist/therapy studies reported in the literature were insufficient in number and research rigor to satisfactorily answer questions regarding the effect of client choice on therapy outcome. Although the present study also failed to provide definitive answers, it did demonstrate that real clients in actual therapy situations reported positive reactions to being able to choose and benefited as much from therapy as clients matched by another method. Further study of the effects of client choice on therapy outcome is clearly warranted.

In a replication of the present study the design should be altered to eliminate the possibility of treatment affecting pretherapy scores. Ratings of expert judges and significant others should be used to supplement client and therapist self-report data. Also, clients should be posttested only upon completion of their therapy. Sample size in future studies should be increased to at least 30 subjects per group. This would help to lessen the marked influence on group means of a few

highly discrepant individual scores.

In this study two methods of matching were compared, client choice and the Clinical Director's own method. Since both may have been equally effective, a third method of random assignment should be included as a control. Finally, it is possible that the treatment procedure was too brief to expect lasting effects. Therefore, initial effects such as client readiness for therapy, quality of early relationship, and client expectations regarding therapy should be more systematically assessed.

The procedure used to present prior information to clients proved to be effective and simple. A similar one could be developed for use in virtually any treatment setting. Additionally, the battery of outcome measures used in the study was short, able to be completed by almost every client, and sampled a variety of behaviors: self-reports of general functioning, improvement on target behaviors, and two objective, unobstructive measures. It, too, is suggested for use in future therapy outcome research.

All of these suggestions, however, should be adjusted to fit the demands and needs of actual therapy settings. While analogue choice of therapist/therapy studies may increase the experimenter's degree of control over extraneous variables, "it seems obvious that any generalization of conclusions from analogue studies cannot be applied directly to natural psychotherapy with any degree of assurance" (Fiske, 1977, p. 36). Field experiments like the present one, on the other hand, will enable a far more productive study of the therapeutic processes involved.

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APPENDICES

Appendix A: Therapists' Self-presentations

Therapist A: I am _____ , a therapist at the WW Johnson Life Center. I earned my batchelor's degree in psychology at the University of New Mexico in 1973, and a Master of Science degree from the University of Massachusetts in Clinical Psychology in 1979. In my life I have had many growth experiences and continue to make good things happen for me. I have done such diverse activities as skydiving, auto racing, and nuclear submarines. But I realize that these activities may not be of interest to you. I have come a long way in my life, from a farm boy in Oklahoma to a Master of Science in Massachusetts; from studying by kerosene lamps at eight years of age to my personal office of today. I have given you personal background as an example of what you too can experience. Through my growth experiences I have discovered ways of overcoming hardships and pain. I am willing to use my experience and knowledge to help you explore what your unique life is and what your specific interests may be. I am strongly committed to the belief that everyone can enjoy life and make good things happen for themselves. Each person is a unique individual and I look forward to each different person as a totally new experience for me. I see myself as therapist learning with each new client and feel that there is a vital new person in everyone. I encourage you to explore, through therapy, the you that needs expression to bring happiness to life.

Therapist B: Hi. My name is _____. When I play basketball, I play to win. Skills and effort is how I make it happen. And I do win. My teams have won championships four out of the last five years.

When I work with people, I work to help each one win. Take a moment, right now, and think: Do you feel like a winner in life? (pause) People whom I have helped extended themselves because each was learning to win with me, and no barrier will stop me from reaching you and helping you win. As a person who wants to help you I will listen and support you in your efforts to become a winner. You say what works and what does not. Together we will make a winning combination so that you reach your goals to make your life complete. Winning builds your confidence, and your confidence helps you keep on winning in life. I look forward to coaching you to your goals.

Therapist C: When people come in to talk to me, they are often nervous and unsure. But they leave more relaxed, walking straighter and more hopeful. Hi, my name is _____ and I work here at the Center. I like how the people I meet with look when they leave, because I know that they leave stronger and more sure. It's an uneasy thing to ask somebody to help. You'll want to know if you will be welcomed, and you want to be treated with dignity, and with respect, for the person you are and the person that you can be. You also want to know if I will work hard for you, listening, understanding, and helping you plan. Growing is sometimes hard work and you need to know that I'll stick in there with you. Working hard and sticking with it are two things that make me who I am. I will use my energy to help you get what you want and what you need. When we get together, we'll look at who you are; we'll look at those things that are missing that you want; and we'll set goals and make plans to get what's missing.

If we do these things, you will feel stronger and more hopeful. I look forward to meeting you so that we can work together.

Therapist D: Hi. My name is _____ . I know that sounds very strange to you because you're not familiar with that kind of name around here. Well, that kind of explains what I'm about. My name was changed from _____ to _____ . And the reason why I decided to change my name was to work on my own personal mental health. Question mark: How does that have anything to do with your own personal mental health? Well, it is important for one to know who they are and where they came from. So each individual's history is a part of their own mental health. Now, to explain that a little further about myself is that when one identifies who they are, they kind of feel more confident about themselves and those things around them. They can accept others better--you have to like yourself before you can like others. And most of us, of color in this country, develop a bad self image. What I mean by a bad self image is that we emulate other people, we try to look like other people rather than be proud of who we are. And that is why my name was changed to _____ _____ . If any of you have watched "Roots", Alex Haley, that kind of explains a little bit. Not that I was exactly a Kunta Kinte*, but, before Alex Haley completed the book, I had already changed my name

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* A first born son that presaged special blessings of Allah on the parents and upon the parents' families. Kunta Kinte was brought to America at 16 to be a slave. Haley, A. Roots. New York: Doubleday, 1976.

and I knew that was very important as a therapist. So my interest in education and mental health is a part of that. And what I'm about is teaching you to get the fullest out of your life, because all of us have some valuable qualities there, and what I want to do is help bring those things out for you.

Therapist E: Recently I had a young lady tell me that she was happy to know me. In asking her why, she explained that she can talk about a lot of things, that she knows I always listen to her and try to help her understand. Hi. I'm _____, a therapist here at the Center. What I just told you about will hopefully demonstrate to you one very important factor of who I am. I am a person who likes and wants to listen to you. Growing up in a large family helped me develop my listening skills. Being from a close knit family and all the other growth experiences I have been through contribute to my strength as the individual you will meet. I am Spanish and have lived in Springfield for 16 years. I offer to listen to who you are, and to talk about whatever is important to you. You might wonder what exactly will happen between you and I as we begin to work together, or what my plans for you will be. I can't be exact about what will happen because you are unique, different from any other person. If we have the opportunity, I will devote to you my energy to listen, understand, and with you develop all the necessary steps to have you work toward your personal goal.

Therapist F: My name is _____ . I am a therapist here at Johnson Life Center. I am a native of Pine Bluff, Arkansas; I completed my undergraduate studies at the University of Arkansas, Pine Bluff, and I completed my Masters degree here in Springfield at American International College. I have been employed at this Center since its inception in 1977. I have worked in the area of mental health for over five years with experiences ranging from psychiatric admissions to community mental health, in both administrative and direct services capacities. I am confident that I have a thorough understanding of the unique mental health problems experienced by disadvantaged individuals, realizing the impact of the social, economic and environmental crushes that tend to cause mental health problems. I am sincere, and I care about the people I serve. If you are ever in need of assistance, I will make myself available to you at your convenience. And, please, do not hesitate to contact me.

Therapist G: Hello. My name is _____ , and I have been working in this field of mental health now for five and a half years. I have been very interested in mental health all my life, just recognizing the need for people to know themselves and know where they want to go so that they can minimize stress and minimize problems to achieve goals on a lifetime basis. My concern in working in mental health has been toward family therapy. My interest has been in family therapy for quite some time now, for approximately three and a half years. I have recognized that family therapy and working with each

member of the family, regardless if one person comes in and requests services, that that person is needing a support unit regardless of who they are. I recognize this myself in working with my own family. Therefore, I feel I am able to utilize information that has been helpful with my family in working with you. Also, through my educational experience having achieved an MSW to date. My role is to assist you in helping yourself get what you want out of life.

Therapist H: Hi. My name's _____ . I'm a therapist here at the Center. Right now I'd like you to take a few moments and think about whether or not you have what you want in life. Is there something important missing for you? (pause) Ok. The people whom I've worked with have expressed to me, that yes something important was missing in their lives. This left them feeling stress because they didn't know how to do anything about it. After working with them, they expressed that I did help them to learn how to get that missing something. If, while you took those few moments, you found that you too have something important missing in your life, I'd like to help you get it. Remember the time when you tried to reach somebody about something and he or she couldn't be reached? That's really frustrating, and that's not the way I work. I am determined to do all I can in helping you to get what you want. That means setting aside appointment times that are convenient for you. That means coming to you when you can't make it to me. And that means being available to you when you most want to reach me. So, let's get together to help you get the relief you want.

Appendix B: Reaction to Center Questionnaire

REACTION TO THE W.W. JOHNSON LIFE CENTER

YOU HAVE JUST HAD YOUR FIRST MEETING AT THE W.W. JOHNSON LIFE CENTER. WE WOULD LIKE TO KNOW YOUR REACTION TO THE CENTER SO FAR.

DIRECTIONS: BELOW ARE A FEW STATEMENTS ABOUT HOW YOU MIGHT BE FEELING NOW. PLEASE SHOW HOW MUCH YOU AGREE OR DISAGREE WITH THE STATEMENTS BY USING THIS SCALE:

	SA	A	AS	U	DS	D	DS
1.....STRONGLY AGREE	(1)	2	3	4	5	6	7
2.....AGREE	1	(2)	3	4	5	6	7
3.....AGREE SOMEWHAT	1	2	(3)	4	5	6	7
4.....UNDECIDED	1	2	3	(4)	5	6	7
5.....DISAGREE SOMEWHAT	1	2	3	4	(5)	6	7
6.....DISAGREE	1	2	3	4	5	(6)	7
7.....STRONGLY DISAGREE	1	2	3	4	5	6	(7)

CIRCLE THE NUMBER THAT BEST DESCRIBES WHAT YOU THINK ABOUT COMING TO THE W.W. JOHNSON LIFE CENTER.

	SA	A	AS	U	DS	D	DS
1. I FEEL THE CENTER RESPECTS ME AS A PERSON.	1	2	3	4	5	6	7
2. I FEEL THE CENTER WILL TAKE A REAL PERSONAL INTEREST IN ME.	1	2	3	4	5	6	7
3. I KNOW WHAT TO EXPECT AT THE CENTER.	1	2	3	4	5	6	7
4. I FEEL I HAVE VERY LITTLE CONTROL OVER WHAT WILL HAPPEN TO ME AT THE CENTER.	1	2	3	4	5	6	7
5. I FEEL INVOLVED IN WHAT IS GOING ON AT THE CENTER.	1	2	3	4	5	6	7

	SA	A	AS	U	DS	D	SS
6. I FEEL UNCOMFORTABLE ABOUT COMING TO THE CENTER.	1	2	3	4	5	6	7
7. I FEEL WILLING TO TALK ABOUT MY PROBLEMS WITH A COUNSELOR.	1	2	3	4	5	6	7
8. I AM DOUBTFUL ABOUT GETTING HELP WITH MY PROBLEM.	1	2	3	4	5	6	7
9. I FEEL LIKE I AM WASTING THE STAFF'S TIME.	1	2	3	4	5	6	7

10. PLEASE LIST ANY OTHER FEELINGS OR THOUGHTS YOU HAVE ABOUT COMING TO THE CENTER. _____

_____

_____

Appendix C: Reaction to Choosing Questionnaire

W.W. JOHNSON LIFE CENTER

REACTION TO CHOOSING YOUR COUNSELOR

YOU HAVE JUST CHOSEN THE COUNSELOR YOU WANT TO WORK WITH AT THE W.W. JOHNSON LIFE CENTER. WE WOULD LIKE TO KNOW WHY YOU CHOSE THAT COUNSELOR.

PART I: DIRECTIONS

FOLLOWING ARE A NUMBER OF QUALITIES SOME COUNSELORS MIGHT HAVE. USING THE FOLLOWING SCALE, PLEASE SHOW HOW IMPORTANT OR UNIMPORTANT EACH ONE WAS TO YOU IN CHOOSING YOUR COUNSELOR.

	VI	I	ND	U	VU
1.....VERY IMPORTANT	(1)	2	3	4	5
2.....IMPORTANT	1	(2)	3	4	5
3.....NOT DECIDED	1	2	(3)	4	5
4.....UNIMPORTANT	1	2	3	(4)	5
5.....VERY UNIMPORTANT	1	2	3	4	(5)

CIRCLE THE NUMBER THAT SHOWS HOW IMPORTANT OR UNIMPORTANT EACH QUALITY WAS TO YOU IN CHOOSING YOUR COUNSELOR

	VI	I	ND	U	VU
1. THE SAME AGE AS I AM.	1	2	3	4	5
2. LOOKS LIKE THE KIND OF PERSON WHO WILL LISTEN TO ME.	1	2	3	4	5
3. THE SAME SEX AS I AM.	1	2	3	4	5
4. REMINDS ME OF SOMEONE I KNOW.	1	2	3	4	5
5. LOOKS STRONG ENOUGH TO HANDLE MY PROBLEMS.	1	2	3	4	5
6. UNDERSTANDING.	1	2	3	4	5

	VI	I	ND	U	VU
7. ATTRACTIVE.	1	2	3	4	5
8. ABLE TO GET THINGS DONE FOR ME.	1	2	3	4	5
9. THE SAME RACE AS I AM.	1	2	3	4	5
10. ABLE TO HELP ME FIGURE OUT WHAT I WANT TO DO.	1	2	3	4	5
11. WE WILL GET ALONG WELL TOGETHER.	1	2	3	4	5
12. WILL TELL ME WHAT TO DO.	1	2	3	4	5
13. FRIENDLY.	1	2	3	4	5

14. THIS LIST CANNOT BE COMPLETE FOR EVERYONE. LIST ANY OTHER QUALITIES THAT WERE IMPORTANT TO YOU THAT ARE NOT INCLUDED ABOVE:

_____

_____

PART II: DIRECTIONS

WE WOULD LIKE TO KNOW HOW YOU FELT ABOUT CHOOSING YOUR OWN COUNSELOR. PLEASE SHOW HOW MUCH YOU AGREE OR DISAGREE WITH THE FOLLOWING STATEMENTS ABOUT CHOOSING YOUR OWN COUNSELOR. USE THE FOLLOWING SCALE:

	SA	A	U	D	SD
1.....STRONGLY AGREE	(1)	2	3	4	5
2.....AGREE	1	(2)	3	4	5
3.....UNDECIDED	1	2	(3)	4	5
4.....DISAGREE	1	2	3	(4)	5
5.....STRONGLY DISAGREE	1	2	3	4	(5)

CIRCLE THE NUMBER THAT BEST DESCRIBES YOUR FEELINGS ABOUT CHOOSING YOUR COUNSELOR.

	SA	A	U	D	SD
1. CHOOSING MADE ME FEEL HOPEFUL ABOUT SOLVING MY PROBLEMS.	1	2	3	4	5
2. CHOOSING MADE ME FEEL OTHERS RESPECT MY OPINIONS.	1	2	3	4	5
3. CHOOSING MADE ME WORRY ABOUT MAKING A BAD CHOICE.	1	2	3	4	5
4. CHOOSING MADE ME FEEL MORE IN CONTROL OF MY LIFE.	1	2	3	4	5
5. CHOOSING CONFUSED ME.	1	2	3	4	5
6. CHOOSING MADE ME MORE WILLING TO TALK OPENLY TO MY COUNSELOR.	1	2	3	4	5
7. CHOOSING MADE ME FEEL RESPONSIBLE FOR MYSELF.	1	2	3	4	5
8. CHOOSING MADE ME FEEL UNIMPORTANT.	1	2	3	4	5
9. CHOOSING A COUNSELOR FOR ME IS THE CENTER'S JOB, NOT MINE.	1	2	3	4	5

10. LIST ANY OTHER WAYS CHOOSING MADE YOU FEEL: _____

_____

_____

Appendix D: General Well-Being Schedule

THE W.W. JOHNSON LIFE CENTER

THE GENERAL WELL-BEING SCALE

NAME: _____

SEX: (M) _____ (F) _____

AGE: _____

READ: THIS SECTION CONTAINS QUESTIONS ABOUT HOW YOU FEEL AND HOW THINGS HAVE BEEN GOING WITH YOU. FOR EACH QUESTION, MARK (X) THE ANSWER WHICH BEST APPLIES TO YOU.

1. HOW HAVE YOU BEEN FEELING IN GENERAL? (DURING THE PAST MONTH)
   - 1 ☐ IN EXCELLENT SPIRITS
   - 2 ☐ IN VERY GOOD SPIRITS
   - 3 ☐ IN GOOD SPIRITS MOSTLY
   - 4 ☐ I HAVE BEEN UP AND DOWN IN SPIRITS A LOT
   - 5 ☐ IN LOW SPIRITS MOSTLY
   - 6 ☐ IN VERY LOW SPIRITS

2. HAVE YOU BEEN BOTHERED BY NERVOUSNESS OR YOUR "NERVES"? (DURING THE PAST MONTH)
   - 1 ☐ EXTREMELY SO--TO THE POINT WHERE I COULD NOT WORK OR TAKE CARE OF THINGS
   - 2 ☐ VERY MUCH SO
   - 3 ☐ QUITE A BIT
   - 4 ☐ SOME--ENOUGH TO BOTHER ME
   - 5 ☐ A LITTLE
   - 6 ☐ NOT AT ALL

3. HAVE YOU BEEN IN FIRM CONTROL OF YOUR BEHAVIOR, THOUGHTS, EMOTIONS OR FEELINGS? (DURING THE PAST MONTH)

1 ☐ YES, DEFINITELY SO
2 ☐ YES, FOR THE MOST PART
3 ☐ GENERALLY SO
4 ☐ NOT TOO WELL
5 ☐ NO, AND I AM SOMEWHAT DISTURBED
6 ☐ NO, AND I AM VERY DISTURBED

4. HAVE YOU FELT SO SAD, DISCOURAGED, HOPELESS, OR HAD SO MANY PROBLEMS THAT YOU WONDERED IF ANYTHING WAS WORTHWHILE? (DURING THE PAST MONTH)

1 ☐ EXTREMELY SO--TO THE POINT THAT I HAVE JUST ABOUT GIVEN UP
2 ☐ VERY MUCH SO
3 ☐ QUITE A BIT
4 ☐ SOME--ENOUGH TO BOTHER ME
5 ☐ A LITTLE BIT
6 ☐ NOT AT ALL

5. HAVE YOU BEEN UNDER OR FELT YOU WERE UNDER ANY STRAIN, STRESS, OR PRESSURE? (DURING THE PAST MONTH)

1 ☐ YES--ALMOST MORE THAN I COULD BEAR OR STAND
2 ☐ YES--QUITE A BIT OF PRESSURE
3 ☐ YES--SOME, MORE THAN USUAL
4 ☐ YES--SOME, BUT ABOUT USUAL
5 ☐ YES--A LITTLE
6 ☐ NOT AT ALL

6. HOW HAPPY, SATISFIED, OR PLEASED HAVE YOU BEEN WITH YOUR PERSONAL LIFE? (DURING THE PAST MONTH)

1 ☐ EXTREMELY HAPPY--COULD NOT HAVE BEEN MORE SATISFIED OR PLEASED
2 ☐ VERY HAPPY
3 ☐ FAIRLY HAPPY
4 ☐ SATISFIED, PLEASED
5 ☐ SOMEWHAT DISSATISFIED
6 ☐ VERY DISSATISFIED

7. HAVE YOU ANY REASON TO WONDER IF YOU WERE LOSING YOUR MIND, OR LOSING CONTROL OVER THE WAY YOU ACT, TALK, THINK, FEEL, OR OF YOUR MEMORY? (DURING THE PAST MONTH)

1 ☐ NOT AT ALL
2 ☐ ONLY A LITTLE
3 ☐ SOME, BUT NOT ENOUGH TO BE CONCERNED OR WORRIED ABOUT
4 ☐ SOME AND I HAVE BEEN A LITTLE CONCERNED
5 ☐ SOME AND I AM QUITE CONCERNED
6 ☐ YES, VERY MUCH SO AND I AM VERY CONCERNED

8. HAVE YOU BEEN ANXIOUS, WORRIED, OR UPSET? (DURING THE PAST MONTH)

1 ☐ EXTREMELY SO--TO THE POINT OF BEING SICK OR ALMOST SICK
2 ☐ VERY MUCH SO
3 ☐ QUITE A BIT
4 ☐ SOME--ENOUGH TO BOTHER ME
5 ☐ A LITTLE BIT
6 ☐ NOT AT ALL

9. HAVE YOU BEEN WAKING UP FRESH AND RESTED? (DURING THE PAST MONTH)

1 ☐ EVERY DAY
2 ☐ MOST EVERY DAY
3 ☐ FAIRLY OFTEN
4 ☐ LESS THAN HALF THE TIME
5 ☐ RARELY
6 ☐ NONE OF THE TIME

10. HAVE YOU BEEN BOTHERED BY ANY ILLNESS, BODILY DISORDER, PAINS, OR FEARS ABOUT YOUR HEALTH? (DURING THE PAST MONTH)

1 ☐ ALL THE TIME
2 ☐ MOST OF THE TIME
3 ☐ A GOOD BIT OF THE TIME
4 ☐ SOME OF THE TIME
5 ☐ A LITTLE OF THE TIME
6 ☐ NONE OF THE TIME

11. HAS YOUR DAILY LIFE BEEN FULL OF THINGS THAT WERE INTERESTING TO YOU? (DURING THE PAST MONTH)

1 ☐ ALL THE TIME
2 ☐ MOST OF THE TIME
3 ☐ A GOOD BIT OF THE TIME
4 ☐ SOME OF THE TIME
5 ☐ A LITTLE OF THE TIME
6 ☐ NONE OF THE TIME

12. HAVE YOU FELT DOWN-HEARTED AND BLUE? (DURING THE PAST MONTH)

1 ☐ ALL OF THE TIME
2 ☐ MOST OF THE TIME
3 ☐ A GOOD BIT OF THE TIME
4 ☐ SOME OF THE TIME
5 ☐ A LITTLE OF THE TIME
6 ☐ NONE OF THE TIME

13. HAVE YOU BEEN FEELING EMOTIONALLY STABLE AND SURE OF YOURSELF? (DURING THE PAST MONTH)

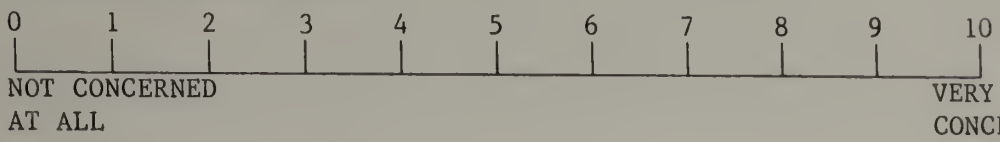
1 ☐ ALL OF THE TIME
2 ☐ MOST OF THE TIME
3 ☐ A GOOD BIT OF THE TIME
4 ☐ SOME OF THE TIME
5 ☐ A LITTLE OF THE TIME
6 ☐ NONE OF THE TIME

14. HAVE YOU FELT TIRED, WORN OUT, USED-UP, EXHAUSTED? (DURING THE PAST MONTH)

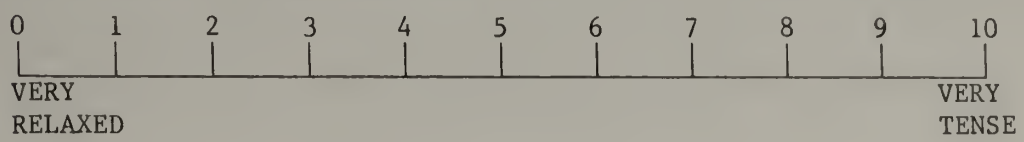
1 ☐ ALL OF THE TIME
2 ☐ MOST OF THE TIME
3 ☐ A GOOD BIT OF THE TIME
4 ☐ SOME OF THE TIME
5 ☐ A LITTLE OF THE TIME
6 ☐ NONE OF THE TIME

READ: FOR EACH OF THE FOUR SCALES BELOW, NOTE THAT THE WORDS AT EACH END OF THE 0-TO-10 SCALE DESCRIBE OPPOSITE FEELINGS. CIRCLE ANY NUMBER ALONG THE BAR WHICH SEEMS CLOSEST TO HOW YOU HAVE GENERALLY FELT DURING THE PAST MONTH.

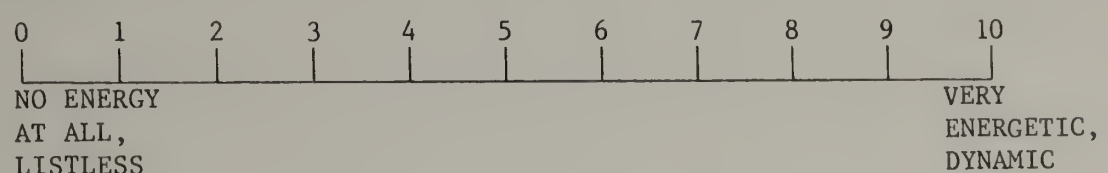
15. HOW CONCERNED OR WORRIED ABOUT YOUR HEALTH HAVE YOU BEEN? (DURING THE PAST MONTH)



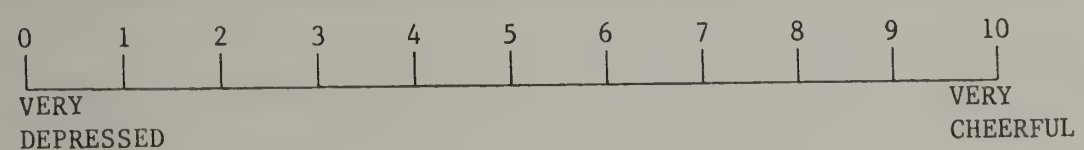
16. HOW RELAXED OR TENSE HAVE YOU BEEN? (DURING THE PAST MONTH)



17. HOW MUCH ENERGY, PEP, VITALITY HAVE YOU FELT? (DURING THE PAST MONTH)



18. HOW DEPRESSED OR CHEERFUL HAVE YOU BEEN? (DURING THE PAST MONTH)



THANK YOU FOR YOUR HELP

Appendix E: Client and Therapist Presenting Problems Forms

W.W. JOHNSON LIFE CENTER

PRETHERAPY PROBLEM RATING FORM

DESCRIBE AS CLEARLY AS YOU CAN THE THREE PROBLEMS YOU NEED HELP WITH THE MOST RIGHT NOW. HOW SERIOUS IS EACH ONE OF THESE PROBLEMS RIGHT NOW? FOR EACH PROBLEM, CIRCLE THE NUMBER WHICH BEST APPLIES.

PROBLEM 1: _____

_____

1	2	3	4	5
NOT SERIOUS	SLIGHTLY SERIOUS	SOMEWHAT SERIOUS	VERY SERIOUS	EXTREMELY SERIOUS

PROBLEM 2: _____

_____

1	2	3	4	5
NOT SERIOUS	SLIGHTLY SERIOUS	SOMEWHAT SERIOUS	VERY SERIOUS	EXTREMELY SERIOUS

PROBLEM 3: _____

_____

1	2	3	4	5
NOT SERIOUS	SLIGHTLY SERIOUS	SOMEWHAT SERIOUS	VERY SERIOUS	EXTREMELY SERIOUS

W.W. JOHNSON LIFE CENTER

PRETHERAPY PROBLEM RATING FORM

CLIENT'S NAME: _____

BELOW ARE THE THREE PROBLEMS IDENTIFIED BY THE CLIENT AS NEEDING HELP THE MOST RIGHT NOW. HOW SERIOUS IS EACH ONE OF THESE PROBLEMS RIGHT NOW? FOR EACH PROBLEM, CIRCLE THE NUMBER WHICH BEST APPLIES.

PROBLEM 1: _____

_____

1	2	3	4	5
NOT SERIOUS	SLIGHTLY SERIOUS	SOMEWHAT SERIOUS	VERY SERIOUS	EXTREMELY SERIOUS

PROBLEM 2: _____

_____

1	2	3	4	5
NOT SERIOUS	SLIGHTLY SERIOUS	SOMEWHAT SERIOUS	VERY SERIOUS	EXTREMELY SERIOUS

PROBLEM 3: _____

_____

1	2	3	4	5
NOT SERIOUS	SLIGHTLY SERIOUS	SOMEWHAT SERIOUS	VERY SERIOUS	EXTREMELY SERIOUS

W.W. JOHNSON LIFE CENTER

POSTTHERAPY PROBLEM RATING FORM

BELOW ARE THE PROBLEMS YOU LISTED WHEN YOU FIRST CAME TO THE CENTER. HOW SERIOUS IS EACH OF THESE PROBLEMS NOW? FOR EACH PROBLEM, CIRCLE THE NUMBER WHICH BEST APPLIES.

PROBLEM 1: _____

_____

1	2	3	4	5
NOT SERIOUS	SLIGHTLY SERIOUS	SOMEWHAT SERIOUS	VERY SERIOUS	EXTREMELY SERIOUS

PROBLEM 2: _____

_____

1	2	3	4	5
NOT SERIOUS	SLIGHTLY SERIOUS	SOMEWHAT SERIOUS	VERY SERIOUS	EXTREMELY SERIOUS

PROBLEM 3: _____

_____

1	2	3	4	5
NOT SERIOUS	SLIGHTLY SERIOUS	SOMEWHAT SERIOUS	VERY SERIOUS	EXTREMELY SERIOUS

CLIENT'S SIGNATURE: _____

DATE: _____

W.W. JOHNSON LIFE CENTER

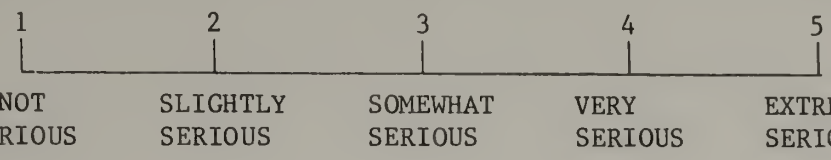
POSTTHERAPY PROBLEM RATING FORM

CLIENT'S NAME: _____

BELOW ARE THE PROBLEMS THIS CLIENT LISTED BEFORE BEGINNING THERAPY. HOW SERIOUS IS EACH OF THESE PROBLEMS NOW? FOR EACH PROBLEM, CIRCLE THE NUMBER WHICH BEST APPLIES.

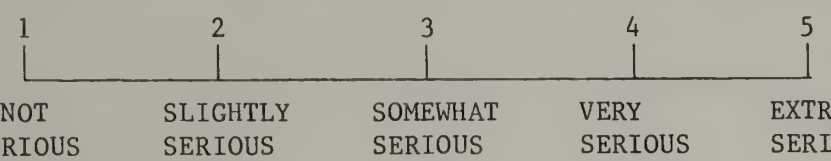
PROBLEM 1: _____

_____



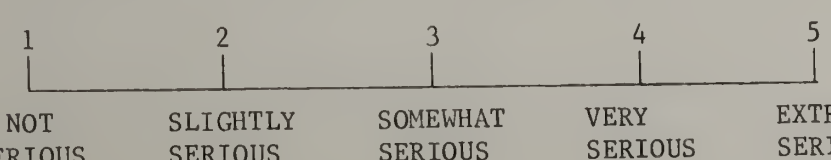
PROBLEM 2: _____

_____



PROBLEM 3: _____

_____



Appendix F: Current Adjustment Rating Scale

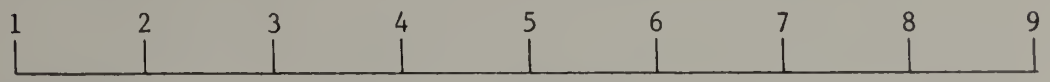
W.W. JOHNSON LIFE CENTER

CURRENT ADJUSTMENT RATING SCALE

CLIENT'S NAME: _____

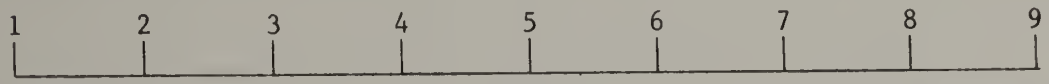
Make your rating for the client by circling the appropriate number along the scales. If you are unsure of your answer, mark it (?) as well as circling a number.

1. Overall global estimate of client's current functioning.



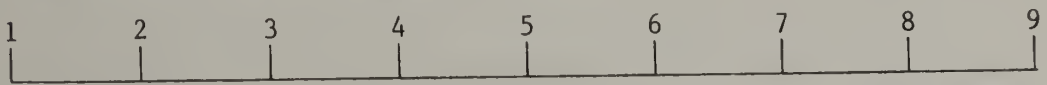
SEVERELY DISTURBED FUNCTIONING — MODERATELY DISTURBED FUNCTIONING — MILDLY IMPAIRED FUNCTIONING

2. Change since one year ago.



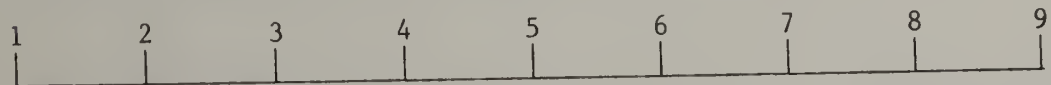
MARKED DETERIORATION — NO CHANGE — MARKED IMPROVEMENT

3. The current work adjustment of client.



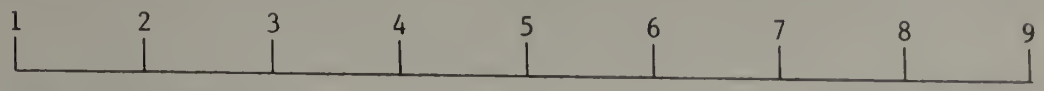
VERY UNHAPPY AND UNPRODUCTIVE — VERY HAPPY AND PRODUCTIVE

4. Current relationships with friends and relatives.



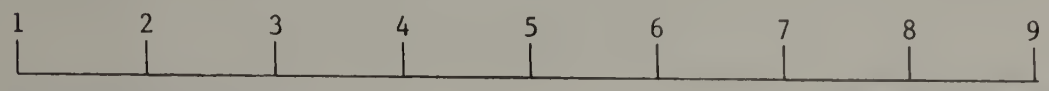
VERY UNSATISFYING FOR CLIENT — VERY SATISFYING FOR CLIENT

5. Current relationships with husband or wife (if not married, to close friend).



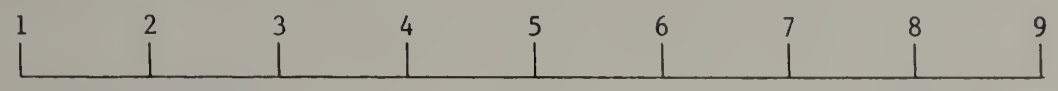
VERY UNSATISFYING FOR CLIENT — VERY SATISFYING FOR CLIENT

6. Adequacy of current life adjustment.



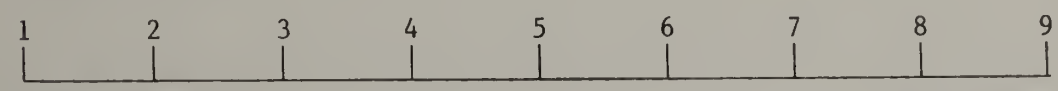
VERY UNSATISFYING FOR CLIENT — VERY SATISFYING FOR CLIENT

7. The current "likeability" of the client: how likeable is he/she to others?



VERY UNLIKEABLE TO OTHERS — VERY LIKEABLE TO OTHERS

8. The current likeability of the client: how likeable is he/she to <u>you</u> the rater?

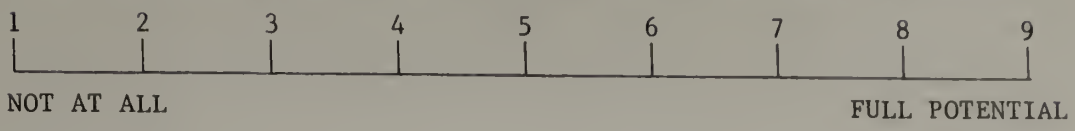


VERY UNLIKEABLE TO ME — VERY LIKEABLE TO ME

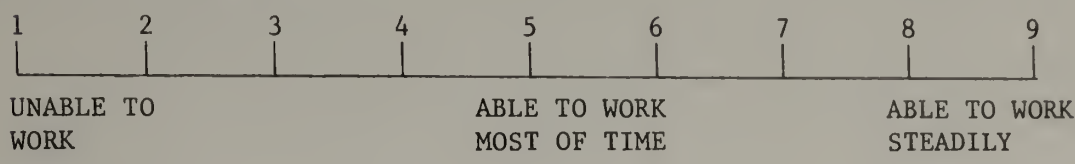
9. To what extent is the client living up to his/her potential in his/her work?

NOT AT ALL — FULL POTENTIAL

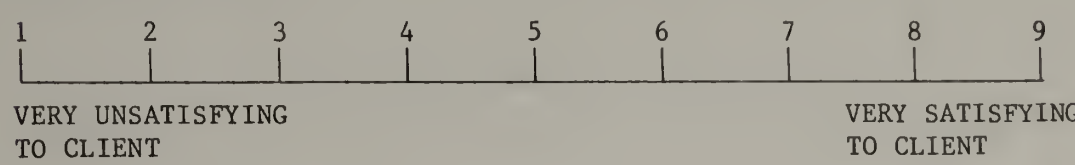
10. To what extent is the client living up to potential as a person?



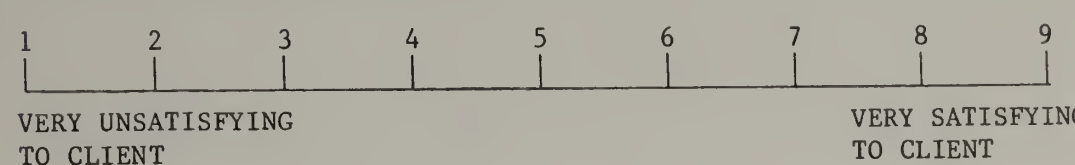
11. Occupational adjustment.



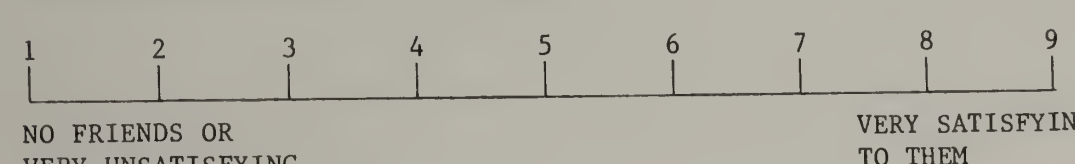
12. Sexual adjustment.



13. Current leisure time activity.



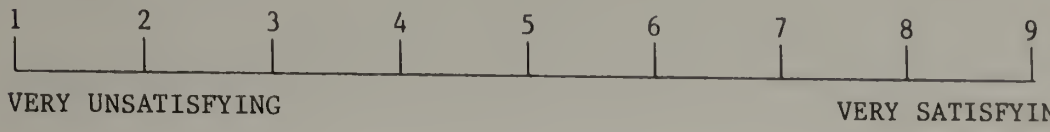
14. Current relationships with friends.



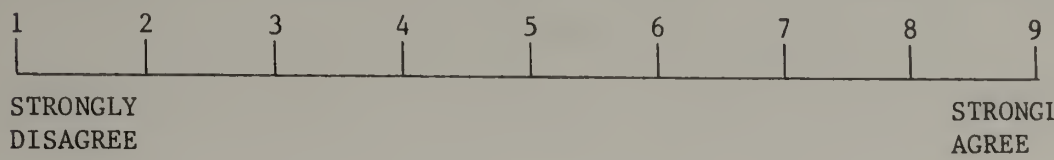
Appendix G: Therapist's Satisfaction with Therapy Questions

These three questions were included as the last three questions of the Posttherapy Current Adjustment Rating Scale.

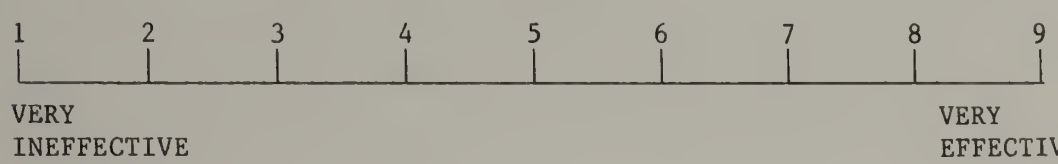
15. Rate your overall satisfaction with the help you were able to give this client.



16. I would like to work with this client again if it becomes necessary.



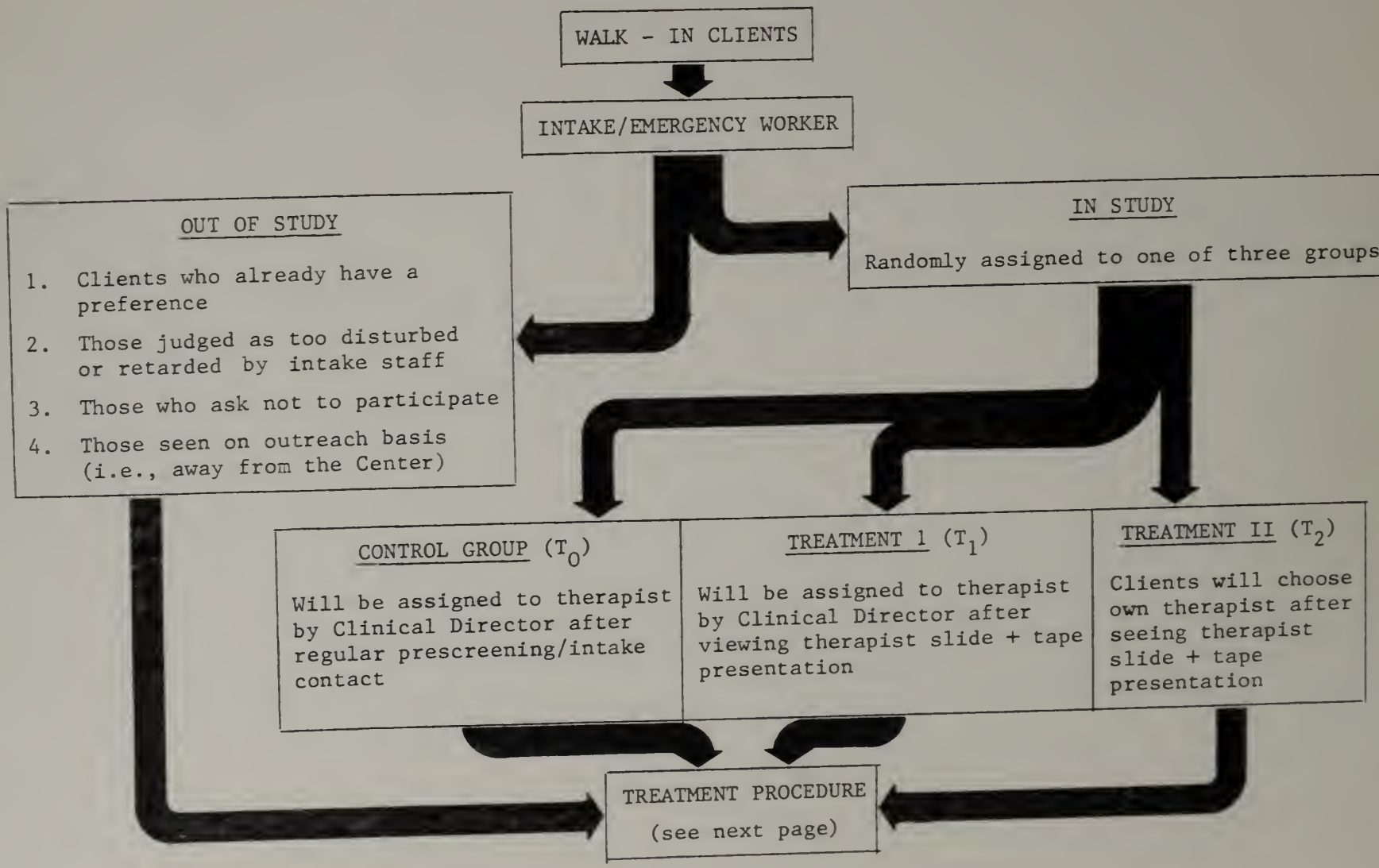
17. Rate your overall effectiveness with this client.



THANK YOU.

Appendix H: Study Procedure Flowchart

PROCEDURE FLOWCHART -- W. W. JOHNSON LIFE CENTER



TREATMENT PROCEDURE -- W. W. JOHNSON LIFE CENTER

PRESCREENING/INTAKE SESSION	FIRST SESSION	LAST SESSION
Seen by: Intake/emergency worker Purpose: 1. Assess and offer assistance 2. Determine if client appropriate for study 3. If T_0 group, assignment to therapist 4. If T_1 I group, view therapist slide-tape, then assignment 5. If T_2 II group, view slide-tape and choose own therapist Forms Completed: 1. All clients: GWBS RECENTER 2. T_2 group: RECHOOSE (two parts)	Seen by: Therapist (either assigned or chosen) Purpose: Begin treatment Forms completed: 1. All clients will complete PPCL 2. Therapists will complete PPTH and CARS for all clients	Seen by: Therapist Purpose: Consolidation of gains and assessment of progress. Done at termination of therapy or three months after Intake Session, whichever comes first Forms completed: 1. All clients will re-take GWBS and PPCL 2. Therapists will complete posttherapy forms of PPTH and CARS

Appendix I: Data and Dependent Variable Correlation Matrix

Key to Data Coding

Sex: 1 = male, 2 = female
Age: in years
Race: 1 = White, 2 = Black, 3 = Hispanic
Presenting Problem: 1 = self, 2 = home, 3 = school, 4 = community, 5 = work
Duration of problem: 1 = <3 mo., 2 = 3-6 mo., 3 = 6-12 mo., 4 = >12 mo.
Previous treatment: 1 = yes, 2 = no
Marital status: 1 = married, 2 = single, 3 = divorced, 4 = separated, 5 = widow/widower
Employment status: 1 = employed, 2 = unemployed
Education: 1-12 = grade completed, 13 = some college, 14 = college degree, 15 = other

RECHOOSE: Reaction to Choosing
RECENTER: Reaction to the Center
PREGWBS: Pretherapy General Well-Being Schedule
PREPPCL: Pretherapy Presenting Problems--Client Form
PREPPTH: Pretherapy Presenting Problems--Therapist Form
PRECARS: Pretherapy Current Adjustment Rating Scle

POSTGWBS: Posttherapy General Well-Being Schedule
POSTPPCL: Posttherapy Presenting Problems--Client Form
POSTPPTH: Posttherapy Presenting Problems--Therapist Form
POSTCARS: Posttherapy Current Adjustment Rating Scale
THERSAT: Therapist Satisfaction with Therapy
SESSIONS: Number of therapy sessions
TERMINATION: Type of termination. 1 = unilateral client decision, 2 = mutual client and therapist decision

CLIENT DATA: T_0 -- IN STUDY (n = 14)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
SEX	2	1	1	1	2	1	1	2	2	2	2	1	2	1
AGE	23	36	39	36	18	28	30	35	24	65	26	17	29	19
RACE	1	1	1	1	2	2	1	2	1	2	1	2	1	2
PRESENTING PROBLEM	1	1	1	1	1	1	1	1	1	1	2	2	2	1
DURATION OF PROBLEM	1	4	1	1	1	3	4	4	4	1	4		4	2
PREVIOUS TREATMENT	1	1	1	1	1	2	1	2	2	2	1	2	1	1
MARITAL STATUS	2	1	3	2	2	2	2	1	2	5	1	2	1	2
EMPLOYMENT STATUS	2		2	1	2	2	2	2	2	2	2	2	1	2
EDUCATION	12	15	6	7	12	13	12	10	10	3	11	12	13	12
THERAPIST	E	C	C	B	C	H	F	A	E	C	F	A	F	B
RECHOOSE														
PART I														
PART II														
RECENTER	20	18	9	34	24	30	25	22	25	9	27	27	18	27
PREGWBS	100	64	27	69	12	83	38	15	22	22	34	52	39	52
PREPPCL	15	9	13	9	14	12	10	11	11	15	15	9	14	10
PREPPTH	14	10	10	15	12	12	15	11	12	13	15	9	15	13
PRECARS	89	73	51	71	48	37	76	43	67	42	43	97	43	40
POSTGWBS	92	75	28	69	71	65	55	61	39	75	68	74	76	89
POSTPPCL	4	6	11	12	10	7	11	5	11	8	9	3	6	6
POSTPPTH	4	9	12	9	10	4	12	7	12	9	6	3	6	4
POSTCARS	106	94	31	74	47	87	87	70	66	83	43	106	44	75
THERSAT	15	15	6	16	13	21	24	17	18	23	9	26	9	18
SESSIONS	4	5	4	12	10	2	9	4	5	14	6	6	11	9
TERMINATION	2	1	2	2	2	1	2	2	2	2	1	2	1	2

CLIENT DATA: T_0 -- DROP-OUTS (n = 9)

	1	2	3	4	5	6	7	8	9
SEX	2	2	1	1	1	2	2	2	1
AGE	21	33	19	23	31	42	22	21	22
RACE	1	2	1	2	1	1	2	1	2
PRESENTING PROBLEM	2	1	1	1	1	1	1	1	1
DURATION OF PROBLEM	1	4	1	4	4	4	3	1	1
PREVIOUS TREATMENT	2	1	1	2	1	2	2	2	1
MARITAL STATUS	2	4	2	4	3	3	2	2	2
EMPLOYMENT STATUS	2	2	2	1	1	2	2	2	2
EDUCATION	12		11	13	12	13	12	12	10
THERAPIST	C	H	A	F	B	C	F	C	B
RECHOOSE:									
PART									
PART II									
RECENTER	35	13	15	20	14	36	16	17	45
PREGWBS	76	50		23	14	47	48	13	28
PREPPCL		10		15	14		13	15	
PREPPTH		10		13	11		15	13	
PRECARS		55		63	80		65	43	
POSTGWBS								72	
POSTPPCL	5							14	
POSTPPTH	10			3	13				
POSTCARS	50			111	53				
THERSAT	8			27	11				
SESSIONS	11	17		10	1	4	7	15	0
TERMINATION	1	1	2	1	1	1	1	2	1

CLIENT DATA: T_1 -- INFORMATION, NO CHOICE (n = 14)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
SEX	1	1	2	2	2	1	2	2	2	2	2	1	1	1
AGE	19	25	40	27	26	36	16	25	64	26	31	29	19	19
RACE		1	2	1	1	1	2	2	1	1	2	2	1	2
PRESENTING PROBLEM	1	1	1		2	2	1	1	2	1	1	1	1	1
DURATION OF PROBLEM	4	4	4		3	3	2	4	4	3		4		
PREVIOUS TREATMENT	1	1	1	1	1	1	2	2	2	1	1	2	1	1
MARITAL STATUS	2	2	3	4	4	4	2	4	1	2	3	2	2	2
EMPLOYMENT STATUS	2	1	2	2	2	2	2	1	1	2	2		2	2
EDUCATION		12	10	11	5	13	12	12	13	13	13	13	12	12
THERAPIST	A	B	C	B	C	B	E	C	C	C	C	B	B	F
RECHOOSE:														
PART I														
PART II														
RECENTER	21	31	26	40	31	23	22	12	22	30	28	32	26	28
PREGWBS	100	64	27	69	12	83	38	36	52	41	36	24	74	69
PREPPCL	15	9	13	9	14	12	10	12	10	9	11	14	7	12
PREPPTH	14	10	10	15	12	12	15	12	10	9	10	9	12	13
PRECARS	89	73	51	71	48	37	76	84	80	57	81	82	74	94
POSTGWBS	92	75	28	69	71	65	55	49	66	78	73	48	53	85
POSTPPCL	4	6	11	12	10	7	11	8	7	6	8	9	11	9
POSTPPTH	4	9	12	9	10	4	12	7	10	6	10	8	10	7
POSTCARS	106	94	31	74	47	87	87	95	81	65	77	84	61	103
THERSAT	15	15	6	16	13	21	24	19	18	11	23	24	15	27
SESSIONS	4	5	14	12	10	2	9	11	2	7	7	12	9	2
TERMINATION	2	2	2	2	2	2	2	2	2	2	2	2	2	2

CLIENT DATA: T_1 DROP-OUTS (n = 9)

	1	2	3	4	5	6	7	8	9
SEX	2	1	2	2	1	1	1	2	2
AGE	68	26	32	30	44	19	18	51	36
RACE	2	1	1	1	2	1	1	1	1
PRESENTING PROBLEM	1	1	1	2	1	2	1	1	1
DURATION OF PROBLEM	4	4	4	3	4	4	1	3	1
PREVIOUS TREATMENT	1	2	2	2	1	1	1	2	2
MARITAL STATUS	5	3	1	1	2	2	2	5	1
EMPLOYMENT STATUS	2	1	1	2	2	2	2	1	2
EDUCATION	9	12	12	10	11	11	11	12	12
THERAPIST	B	A	C	E	F	B	F	E	H
RECHOOSE:									
PART I									
PART II									
RECENTER	29	26	27	14	15	13	24	9	24
PREGWBS	61	35		17	25	11	26		59
PREPPCL	15		8	14	14	14			
PREPPTH	12		9	14	11	13			
PRECARS	78		91	65	57	71			
POSTGWBS			79						
POSTPPCL	2		6						
POSTPPTH	11		8			9			
POSTCARS	55		98			86			
THERSAT	4		15			18			
SESSIONS	7	0	4	4	2	4	0	4	0
TERMINATION	1	1	1	2	2	1	1	2	1

CLIENT DATA: T_2 -- INFORMATION PLUS CHOICE (n = 14)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
SEX	1	2	1	2	2	1	1	2	1	2	2	1	1	2
AGE	22	44	25	22	28	30	21	25	18	37	19	23	25	24
RACE	2	2	1	1	2	2	1	1	1	1	2	2	1	1
PRESENTING PROBLEM	1	1	1	1	1	4	1	1	1	1	1	1	4	4
DURATION OF PROBLEM	4	4	1	4	4	4	1	4	2	1	4	1	1	1
PREVIOUS TREATMENT	1	2	2	1	1	1	1	1	1	1	2	1	2	2
MARITAL STATUS	2	4	1	2	1	2	2	2	2	1	2	2	1	1
EMPLOYMENT STATUS	1	2	1	2	2	2	2	2	2	2	2	2		
EDUCATION	11	11	13	13	12	13	4	13	12	13	11	11	12	12
THERAPIST	B	D	A	E	F	E	A	C	C	A	E	A	C	C
RECHOOSE:														
PART I	32	30	22	39	41	35	36	36	21	42	34	30	41	40
PART II	20	16	9	22	14	24	16	18	15	14	25	17	15	24
RECENTER	17	14	9	24	25	12	26	29	33	24	42	23	15	18
PREGWBS	39	28	57	27	36	98	84	37	34	27	46	82	63	105
PREPPCL	12	15	11	12	11	11	11	12	13	11	15	11	8	11
PREPPTH	12	15	12	12	13	8	11	11	13	12	13	11	12	13
PRECARS	53	67	72	35	53	67	48	44	36	47	68	44	39	35
POSTGWBS	61	79	24	48	63	93	80	40	84	54	71	88	81	105
POSTPPCL	3	3	15	10	10	14	7	10	10	6	3	3	6	5
POSTPPTH	3	3	13	11	15	10	11	8	11	9	3	3	9	7
POSTCARS	100	122	78	43	47	88	47	86	45	67	105	85	64	57
THERSAT	24	27	27	5	21	23	19	25	21	22	27	18	17	15
SESSIONS	2	2	4	9	15	15	8	7	10	3	10	1	14	15
TERMINATION	2	2	2	2	2	1	2	2	2	2	2	2	2	2

CLIENT DATA: T_2 DROP-OUTS (N = 9)

	1	2	3	4	5	6	7	8	9
SEX	2	1	1	2	1	2	2	2	1
AGE	38	59	22	24	26	35	49	18	24
RACE	1	2	1	3	2	2	1	2	1
PRESENTING PROBLEM	1	1	1	1	1	1	1	1	1
DURATION OF PROBLEM	1		1	1	2	4	2	4	1
PREVIOUS TREATMENT	1	2	1	1	2	1	1		2
MARITAL STATUS	1	3	2	1	2	4	2	2	2
EMPLOYMENT STATUS	2	2	1	1	1	2	2	2	2
EDUCATION	12	9	13	14	12	12		11	12
THERAPIST	A	D	C	A	F	A	E	C	C
RECHOOSE:									
PART I	35	26	45	43	41	22	31	23	25
PART II	23		19	24	26	16	16	23	15
RECENTER	19	23	13	15	28	23	34	27	17
PREGWBS	92	57	15	28	70	54	33	58	26
PREPPCL	6			10		15	12		
PREPPTH	7			10		11	11		
PRECARS	37			73		39	82		
POSTGWBS									
POSTPPCL									
POSTPPTH									
POSTCARS									
THERSAT									
SESSIONS	8	4	0	1	0	4	2	0	2
TERMINATION	2	1	1	1	1	2	1	1	1

CLIENT DATA: NOT IN STUDY (n = 18)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
SEX	1	2	2	2	2	1	1	2	1	2	2	2	2	1	1	2	1	1
AGE	42	52		24	24	33	30	63	69	42	24	27	65	19	21	35	37	32
RACE	2	2	1	3	2	2	2	1	1	1	3	1	1	1	2	2	2	1
PRESENTING PROBLEM	1	1	2		1	1	1	1	1	1	1	2	1	1	1	1	1	5
DURATION OF PROBLEM	4	4	4		4		4	4	4	4	4	4	3	1	4	1	1	1
PREVIOUS TREATMENT	1		2	1	1	1	1	1	2	1	1	1	2	1	1	1	2	2
MARITAL STATUS	1	3	1	2	1	2	2	3	1	3	1	2	5	2	2	5	2	3
EMPLOYMENT STATUS	1	2	1	2	2	2	2	2	2	2	2	2	2	2	2	2	2	1
EDUCATION	13		13	5		12	13	9	9	10	3	12	12	11		6	9	8

INTERCORRELATIONS AMONG 10 OUTCOME VARIABLES

	POSTGWBS	POSTPPCL	POSTPPTH	POSTCARS	THERSAT	SESSIONS	PREGWBS	PREPPCL	PREPPTH	PRECARS
POSTGWBS	1.000									
POSTPPCL	-.518	1.000								
POSTPPTH	-.435	.789	1.000							
POSTCARS	.259	-.433	-.580	1.000						
THERSAT	.040	-.070	-.165	.679	1.000					
SESSIONS	.036	.198	.208	-.357	-.233	1.000				
PREGWBS	.518	-.125	-.230	.228	.041	-.054	1.000			
PREPPCL	-.087	-.052	-.150	-.043	-.002	.097	-.350	1.000		
PREPPTH	.055	.004	-.032	-.092	-.112	.088	-.065	.356	1.000	
PRECARS	-.013	-.003	-.078	.641	.418	.170	.110	-.157	-.198	1.000